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BLOCK GRANTS AND OTHER HEALTH SERVICE PROGRAMS, 1984

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

REVIEW OF EXPIRING PUBLIC HEALTH SERVICE ACT REAUTHORIZATIONS IN ORDER TO IMPROVE THE HEALTH AND WELL-BEING OF THE AMERICAN PEOPLE

FEBRUARY 22; MARCH 7 AND 14, 1984

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BLOCK GRANTS AND OTHER HEALTH SERVICE PROGRAMS, 1984

WEDNESDAY, FEBRUARY 22, 1984

U.S. Senate,
Committee on Labor and Human Resources,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room SD-430, Dirksen Senate Office Building, Senator Charles E. Grassley presiding, pro tempore.

Present: Senators Hatch, Grassley, Pell, Eagleton, and Thurmond.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator **Grassley** [presiding]. I am Senator Chuck Grassley. I am sitting in for the distinguished chairman of this committee, Senator Hatch, who will be momentarily detained and will be along shortly.

I would like to announce for the public at large that today is the first of 2 days of hearings to consider five major Public Health Service Act reauthorizations. The bills we are here to consider will have a significant impact on our quest to improve the health and well-being of the American people.

Briefly summarizing the health programs involved, there are first the three block grant reauthorizations: S. 2303, the alcohol, drug abuse and mental health block grant; S. 2301, the preventive health services block grant; S. 2308, the primary care block grant. Second, there are two equally important legislative measures: S. 2281, the National Health Service Corps Amendments of 1984; and S. 2311, the Health Maintenance Organization Amendments of 1984.

Today's first panel will provide us with the views of the administration, presented by the distinguished Assistant Secretary of Health, Dr. Edward M. Brandt, discussing all five of the bills that we will consider over the next 2 days. Following him today will be a panel on the alcohol, drug abuse and mental health block grant and a panel on the HMO reauthorization.

On March 7, during our second day of reauthorization hearings, we will continue with panels on the preventive health services block grant, the primary care block grant, and the National Health Services Corps reauthorization.

As many of you already know, 3 years ago this committee was engaged in President Reagan's initiative to transfer Federal categorical programs to the States through the block grants. In large part, we succeeded. And we are obviously pleased to have witnessed since then that the programs have worked well as we revised them. Local and State governments have masterfully taken over the task of providing designated services under the various Public Health Service block grants. As a result, States have been able to target their efforts where they are most needed. As we review these block grant initiatives, we must reaffirm our commitment to allow the States to direct these services.

Let me now briefly review each of the pieces of legislation. I think for the benefit of time, I am not going to go through the rest of my testimony.

So I would call upon my distinguished colleague, who has once again taken a position on this very important committee, Senator Strom Thurmond, and ask if he has any comments at this point.

Do you have any comments, Senator Thurmond?

STATEMENT OF SENATOR STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Senator **Thurmond**. Thank you very much, Mr. Chairman.

This is the first session that I have attended on this committee. I have just been added as a new member here. I was on this committee many years ago and then moved off. I am very glad to be back.

This committee considers many important matters. There is nothing more important to the American people than health. And I am very pleased to be here and do what I can to stimulate interest in health, and I am very glad to see these splendid witnesses here today.

I have got to go to open the Senate in a few minutes, but I will read the record here. I want you gentlemen to know that I am very vitally interested in what you say and what you do because there is nothing that would do more to help the American people, I think, than to promote their health. You are in a position to do this.

Thank you very much.

Senator **Grassley**. Thank you, Senator Thurmond.

We welcome here today, as I previously said, Dr. Edward N. Brandt, Jr., the Assistant Secretary for Health in the Department of Health and Human Services. He is accompanied, I am informed, by Dr. Robert Graham, who is the Administrator of the Health Resources and Services Administration; Dr. James Mason, who is head of the Center for Disease Control; and Dr. Robert Trachtenberg, Deputy Administrator of Alcohol, Drug Abuse and Mental Health.

Would you proceed, Dr. Brandt? And if I made any errors in the introduction of anybody, correct them and add if there is anybody at the table you want us to know about in addition to the ones I introduced.

STATEMENT OF EDWARD N. BRANDT, JR., M.D., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT TRACHTENBERG, ACTING ADMINISTRATOR, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION; JAMES MASON, DIRECTOR, CENTERS FOR DISEASE CONTROL; ROBERT GRAHAM, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION; DR. JOHN MARSHALL, DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH; AND DR. MANNING FEINLEIB, DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS

Dr. BRANDT. Thank you very much, Senator Grassley and Senator Thurmond. I appreciate the opportunity to appear here today to discuss with you the reauthorization of Public Health Service Programs which expire at the end of fiscal 1984. With me are the officials who head various units of the Public Health Service that administer these programs, and I would simply like to introduce the remaining two people: to my far right, Dr. John Marshall, who is Director of the National Center for Health Services Research; and to his left, Dr. Manning Feinleib, who is Director of the National Center for Health Statistics.

I will address the programs for services to individuals, including the alcohol, drug abuse and mental health services block grants, preventive health and health services block grant, and the primary care block grant, as well as the National Health Service Corps field program.

I also wish to discuss expiring project grant programs for immunization, for control of sexually transmitted diseases, and for our programs of health statistics and health services research.

We appreciate very much the interest of this committee and that of Chairman Hatch and the concern for these important programs. We're reviewing bills that have been introduced to extend and modify many of them, including the Primary Care Block Grant Amendments of 1984, the Alcohol, Drug Abuse and Mental Health Services Block Grant Amendments of 1984, the Home Health Services, Preventive Health Services, and Home and Community Based Services Act of 1984, and the National Service Corps Amendments of 1984.

While there are features in these bills that we do not support, we do welcome certain important elements of them, and these bills and the administration's proposals are a foundation for our collaboration on improvements in these programs.

I sincerely hope that we can address them together in the interest of making these programs work even better in the service of goals we all share.

I look forward, as do my colleagues, to working with you.

These programs are key in accomplishing our priorities for public health. Their renewal, and certain changes we will be recommending, would move us toward accomplishing several of our objectives, including achieving the Department's prevention goals, with particular attention to the 1990 objectives, maintaining a strong Federal commitment to health research, expanding private institution participation in many PHS activities, improving our data base, particularly regarding health and illness, health care technology, and the delivery of health services; and finally, strengthening the State and local government capacity to manage public health programs.

To recall for a moment the basic philosophy of the block grant, the President, as you know, proposed to Congress shortly after he took office that there be two health block grant programs consolidating a total of 25 separate categorial programs that we believe should be operated and would be operated better by the States.

The Congress, in the Omnibus Budget Reconciliation Act of 1981, created four health blocks—the three that we are considering today and the Maternal and Child Health Block Grant Program.

This restructuring of Federal assistance springs from our conviction that the State and State health authorities are better able to allocate funds for health programs within their boundaries than is the Federal Government.

The tasks of identifying the specialized requirements of geographical areas, targeting resources, making resource allocation, and monitoring the success of these activities all require closeness to the situation and a sensitivity to local conditions that call for State administration and State involvement.

Our experience has taught us that this basic philosophy was correct. All indications are that the block grant mechanism is working smoothly. Early reports on results of studies conducted by the Urban Institute and by the General Accounting Office indicate that States are using these Federal funds to address their own unique health care problems.

Mr. Chairman, I address the operation of two of these block grant programs in my statement, and I would now, however, like to spend a little bit of time on the primary care block.

This block grant program provides funds to assist States in providing primary health services to medically underserved populations and, as currently constituted, includes only the community health centers program. Participation by the States is not required. The Public Health Service continues to award and administer categorical grants to community health centers in those States which have not chosen to participate.

During fiscal year 1983 the Health Resources and Services Administration awarded grants to West Virginia and the Virgin Islands. In fiscal year 1984 the Virgin Islands will continue to participate. West Virginia, which received an award earlier this year, is now negotiating with us to return it, since their State legislature has directed that the State withdraw from the program.

The poor acceptance of this block grant by the States is a lesson that the program as designed is not an effective one. And thus we will be seeking to modify it. We are recommending to the Congress that this block grant include existing project grant programs which ought, in our view, to be administered by the States, including family planning, migrant health, and black lung clinics, in addition to community health centers.

This approach not only makes good sense from the standpoint of management and administration, it also is a more effective way of organizing health care. The various services provided by past and present categorical programs ought to be organized together so that a person who obtains care from these programs is not dealing with a series of independent, unrelated programs, often located at geographically discrete points.

The block grant, as we envision it, eliminates the administrative distinctions between services and lets the States deliver services in a coordinated fashion according to the basic philosophy of primary care.

We are also recommending other changes to make this program more appealing to the States. Our experience so far has convinced us that more flexibility and more freedom at the State level is required. Specifically, we wish to make the block grants the sole way of funding community health centers and other project grant activities within a State. We wish to eliminate the requirement for State matching funds. We wish to allow States to determine which projects to fund, and we wish to eliminate the requirement that States administer community health centers in accordance with the PHS Act's current concept of a project grant program.

Again, I would like to emphasize, Mr. Chairman, that we hope to work with you closely on this to try to move toward the freedom and flexibility that the States need.

We will ask for renewal authorities for these three block grant programs in title XIX of the PHS Act and for certain changes to improve the effectiveness and efficiency of block grant administration.

We also propose for fiscal year 1985 to place the administration of the health block grants in the Office of the Assistant Secretary for Health. This will allow greater consistency in administration and provides States with a single focal point for resolving block grant administrative issues. Technical and programmatic issues, however, will still be dealt with by experts within the agency's professional staff, who are in fact, and who are expert in fact, in the particulars of the health issues concerned.

Turning now to the National Health Service Corps field programs, the National Health Service Corps, administered by the Health Resources and Services Administration, has been a significant factor in distributing medical and other health personnel to health manpower shortage areas. There now are 2,865 National Health Service Corps practitioners in 1,600 shortage areas, making available health care to approximately 2,280,000 people.

Most of the practitioners now coming available for service are fulfilling service obligations or repayment of tuition costs paid several years ago.

For fiscal year 1985 we project a Federal field strength of 1,150 Federal officers and employees plus an additional 2,433 serving in private practice option and private placement assignments to fulfill their obligations.

These private, fee-for-service practices in shortage areas accomplish the objectives of the program without requiring Federal physicians.

We seek renewal of the field program, authorized under section 338 of the Public Health Service Act. While the increase in the number of available physicians in our society will result in fewer shortage areas, there may still be areas for which this program will continue to be the only supplier of health services.

For scholarships, we are not asking for a renewal of authorization for the scholarship program which expires this year, because the needs of the field program do not call for additional scholarships at this time. However, in the late 1980's the number of scholarship-obligated practitioners should decline, and we are in the process of developing a new, more efficient approach to meeting the personnel requirements over the next decade

We are requesting reauthorization of the program of project grants for immunization services operated by the Centers for Disease Control. In the 21 years since grants for this program first were authorized, it has been one of the most successful Public Health Programs in the United States. Local and State health departments, working with their colleagues in the private sector, have raised immunization levels in American children to the highest point ever and have reduced to the lowest levels ever the incidence of the diseases against which we vaccinate children.

The statistics are truly encouraging. Declines of greater than 99 percent have been obtained for most of these diseases, and over 87 percent for all of them. For children entering school for the first time in the fall of 1983, more than 95 percent presented proof of immunization against diphtheria, tetanus, pertussis, measles, rubella, mumps, and polio.

And I would like to point out, Mr. Chairman, that in the 1990 objectives which were published in 1980, that this level was projected, to be reached in 1990, but has already been reached in 1983, 7 years ahead of schedule.

This amazing progress results from highly effective collaboration between the public and private sectors and among all levels of government.

Experience has shown that it is often necessary to vaccinate older children and adults who may have escaped both natural infection and immunization in the past. Our hope is to include within the State and county efforts some of these persons who are at special risk. For example, in recent years, more than half of rubella cases in this country have occurred in persons 15 years of age or older.

We also seek renewal of the program of project grants for control of sexually transmitted diseases. This program also is a fine example of the successful partnership between local, State, and Federal agencies. The collaborative effort is best exemplified by the gonorrhea control program begun nationally in 1972. The Federal Government, with its active support, contributed to the dramatic reversal of the spiralling morbidity. By the middle of the 1970's, reported gonorrhea morbidity had already begun to stabilize, and decreases became readily apparent in the 1980's, despite the growing size of the population at risk.

The case of syphilis is a bit more complicated, and it is instructive. To some extent, the national gains in gonorrhea control were made possible, in part, by diverting some resources to syphilis control efforts. While gonorrhea was stabilizing in the middle of the decade, reported syphilis cases began to increase steadily with each successive year.

Current trends, however, warrant cautious optimism. In 1983, the number of reported cases of early infectitious syphilis remained virtually unchanged compared to the corresponding number reported for 1982. These illnesses, however, still present reason for our continued concern, and I have detailed specifically the reasons for that.

It is important not to repeat the mistakes of the past, when advances comparable to those we are now witnessing prompted us to withdraw Federal resources to support syphilis control, leading to a resurgence of the disease as a public health problem in the 1960's.

The opportunity of States to make further advances in the control of sexually transmitted diseases has never been greater.

Let me now turn to our program of health services research carried out through the National Center for Health Services Research, which we also wish reauthorized.

This Center is the focal point within the Federal Government for research on the health care delivery system. It provides information that is used to improve the effectiveness, efficiency, and distribution of health care services within the United States. Its research is designed not only to meet the needs of the Department, but those of Congress, the States, local governments, health care providers, and consumers as well.

To this end, the Center supports an extramural research grant program based on peer review of investigator-initiated research. It seeks to develop the knowledge base for future policies, as it did, for example, in the developmental work on many key features of modern health care delivery, including the development of diagnosis-related groups, the so-called DRG's, the development of the computer-stored ambulatory records system, which is now the most widely used automated medical records system in the United States, and the demonstration of the value and effectiveness of nurse practitioners and physician assistants.

The Center also has a number of other extramural projects now underway, and some of those we have provided information on.

We also have an intramural research program, which is a steady source of timely technical assistance to congressional committees, the Congressional Budget Office, Department of the Treasury, and the Office of Management and Budget.

It operates a user liaison program to disseminate the findings of health services research projects, and it is a key participant in our technology assessment activities. Indeed, the Office of Health Technology Assessment conducts evaluation of new and existing technologies for purpose of coverage determinations under medicare. This is an activity that continues to be pertinent to the national dilemma of controlling health care costs without compromising quality of care.

Another essential contribution to the national health effort is our statistical program, again a portion for which we seek renewal. It is conducted by the National Center for Health Statistics, which is the Federal Government's general purpose health statistics agency. Its data systems address the full spectrum of concern in the health field from birth to death.

The Center maintains over a dozen surveys that collect health information through personal interviews, physical examinations, laboratory testing, review of hospital, nursing home, and physician records, and other means.

Again, these data systems and the analysis that flow from them are designed to provide information useful to a variety of users. One such example is the comprehensive annual report entitled, "Health, United States," the 1983 version of which was recently submitted to the President and the Congress by Secretary Heckler.

I have also detailed, Mr. Chairman, several of the examples of important uses of these data.

This concludes, Mr. Chairman, my prepared statement. We stand ready to work with the committee on the reauthorization legislation, and I and my colleagues will be happy to answer any questions that you may have.

[The prepared statement of Dr. Brandt follows:]

For release only upon delivery

STATEMENT
OF
EDWARD N. BRANDT, JR., M.D.

ASSISTANT SECRETARY FOR HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
FEBRUARY 22, 1984

Mr. Chairman, and members of the Committee:

I appreciate the opportunity to appear here today to discuss with you the reauthorization of Public Health Service programs which expire at the end of Fiscal Year 1984.

With me are the officials who head the units of the Public Health Service that administer these programs, and I would like to introduce them to you. They are Mr. Robert Trachtenberg, Acting Administrator, Alcohol, Drug Abuse, and Mental Health Administration; Dr. James Mason, Director, Centers for Disease Control; Dr. Robert Graham, Administrator, Health Resources and Services Administration; Dr. John Marshall, Director, National Center for Health Services Research; and Dr. Manning Feinleib, Director, National Center for Health Statistics.

I will address the programs for services to individuals, including the Alcohol and Drug Abuse and Mental Health Services Block Grant, the Preventive Health and Health Services Block Grant, and the Primary Care Block Grant, as well as the National Health Service Corps (NHSC) field program. I will also discuss expiring project grant programs for immunization and for control of sexually transmitted diseases, and expiring authorities for our programs of health statistics and health services research.

We appreciate your interest in and concern for these important programs. We are reviewing the bills you have introduced to extend and modify many of them -- the Primary Care Block Grant Amendments of 1984 (S. 2308), the Alcohol and Drug Abuse and Mental Health Services Block Grant Amendments of 1984 (S. 2303), the Home Health Services, Preventive Health Services and Home and Community-Based Services Act of 1984 (S. 2301), and the National Health Service Corps Amendments of 1984 (S. 2281). While there are features in these bills that we do not support, we do welcome certain important elements of them, and these bills and the Administration's proposals are a foundation for our collaboration on improvements in these programs. I hope we can address them together, in the interests of making these programs work even better in the service of goals we all share. I am looking forward to working with you.

These programs are key in accomplishing our priorities for public health. Their renewal, and certain changes we are recommending, would move us toward accomplishing several of our objectives, including:

- o Achieving the Department's prevention goals, with particular attention to the 1990 objectives;
- o Maintaining a strong Federal commitment to health research;

- Expanding private institution participation in many PHS activities;
- Improving the public health data base, particularly regarding health and illness, health care technology, and the delivery of health services;
- Strengthening State and local government capacity to manage public health programs.

Block Grants

Let me discuss first the basic philosophy of the block grants. As you recall, the President proposed to Congress, shortly after he took office, that there be two health block grant programs, consolidating a total of 25 separate categorical programs that we believed should be operated by the States rather than the Federal government. The Congress, in the Omnibus Budget Reconciliation Act of 1981 (which the President signed on August 13, 1981), created four health block grant programs -- the three that we are addressing today, and the Maternal and Child Health Block Grant Program -- which subsume most of the former separate categorical grant programs. This restructuring of Federal assistance springs from our conviction that the States are better able to allocate funds for health programs within their boundaries than is the Federal government. The tasks of identifying the specialized requirements of geographical areas, targeting resources on underserved populations, making resource allocations among competing needs, and monitoring the success of health service activities, all require closeness to the situation and a sensitivity to local conditions that call for State administration.

Our experience has taught us that this basic philosophy was correct. All indications are that the block grant mechanism is working smoothly. Early reports on results of studies conducted by the Urban Institute and GAO indicate that States are using these Federal funds to address their own unique health care problems.

Let me describe the operation of each of these programs.

Alcohol and Drug Abuse and Mental Health Services

This program provides funds to the States in support of their alcohol, drug abuse and mental health activities, for prevention, treatment, and rehabilitation services. It consolidated a series of separate grant programs: alcoholism State formula grants, alcohol abuse and alcoholism project grants and contracts, drug abuse State formula grants, drug abuse statewide services grants, and community mental health centers. ADAMHA, which currently administers this block grant, has made grants to all 57 jurisdictions and to two of the eligible Indian tribes and tribal organizations which have applied for grants.

The States have in large measure continued the array of programs that had been funded under the categorical programs. But certain trends are emerging with regard to States' choice of target populations. Within State mental health programs, the chronically mentally ill are receiving the highest priority. Within State drug abuse programs, opiate abusers appear to be receiving the highest priority, especially in States with large urban populations. A number of States reported that they are giving higher priority to the alcohol, drug abuse, and mental heath programs in urban areas.

Preventive Health and Health Services

This program provides States with funds for preventive health services for individuals and families and for a variety of public health services to reduce preventable morbidity and mortality and to improve quality of life.

It consolidated the prior categorical programs for hypertension control, comprehensive public health services, risk reduction and health education, rodent control, emergency medical services, fluoridation, and home health services. Since FY 1982 the Centers for Disease Control, which now administers this block grant, has made block grant awards to all 57 eligible entities -- States, territories, and insular areas -- and to the two Indian tribal organizations eligible to receive grants directly. There is a separate allotment of $3 million for providing services to rape victims and for rape prevention, distributed to the States according to population. The States have continued the majority of State-level programs funded under the categorical programs. For example, States continue to allocate block grant and State funds to the 1990 national health promotion objectives. They are placing emphasis on technical assistance to communities within the States. This assistance is designed to help communities identify high-priority problems locally, based on local-area data, and to launch community risk reduction initiatives. Many communities are generating local resources for these types of programs.

To acknowledge the work States and localities are doing in health promotion, the Secretary was pleased this year to recognize 161 community projects nominated by 40 State health departments by presenting awards and certificates of merit for excellence in health promotion. These projects illustrate the beneficial interaction of combined Federal, State, and local resources and efforts.

Primary Care

This block grant program provides funds to assist States in providing primary health services to medically underserved populations, and currently includes only the commmunity health centers program. Participation is not required; the Public Health Service continues to award and administer categorical grants to community health centers in those States which have not chosen to participate. During FY 1983 the Health Resources and Services Administration, which administers this program, awarded grants to West Virginia and the Virgin Islands. In FY 1984, the Virgin Islands will continue to participate in the program. West Virginia, which received an award earlier this year, is now negotiating with us to return it; the State legislature has directed that the State withdraw from the program.

The poor acceptance of this block grant by the States is a lesson that the program as designed is not an effective one, and thus we seek to modify it. We are recommending to the Congress that this block grant include existing project grant programs which ought, in our view, to be administered by the States -- family planning, migrant health, and black lung clinics. This approach makes good sense not only from the standpoint of management and administration -- it is also a better way of organizing health care. The various services provided by past and present categorical programs ought to be organized together, so that a person who obtains care from these programs is not dealing with a series of independent, unrelated programs. The block grant as we envision it eliminates the administrative distinctions between services, and lets the States deliver services in a coordinated fashion.

We are also recommending other changes to make this program more appealing to the States. Our experience so far has convinced us that more flexibility, more freedom, at the State level, is needed. We believe our proposals to this effect will be welcomed by the States.

Specifically, we wish to make the block grant the sole way of funding community health centers and other project grant activities within a State; to eliminate the requirement for State matching funds; to allow States to determine which projects to fund; and to eliminate the requirement that States administer community health centers in accordance with the PHS

Act's present concept of a project grant program. I hope to work with you closely on this, to try to move toward the freedom and flexibility the States need.

Renewal of Block Grant Programs

We ask for renewal of authorities for these three block grants in title XIX of the PHS Act, and for certain changes to improve the effectiveness and efficiency of block grant administration.

We also propose for FY 1985 to place the administration of the health block grants in the Office of the Assistant Secretary for Health. This will allow greater consistency in administration and provide States with a single focal point for resolving block grant administrative issues. Technical and programmatic issues will still be dealt with by agency professional staff who are expert in the particulars of the health issues in the programs.

National Health Service Corps Field Program

In the years since 1970, the National Health Service Corps, administered by the Health Resources and Services Administration, was a significant factor in distributing medical and other health personnel to health manpower shortage areas. The designated areas were low income or geographically or culturally isolated, or perceived as having deficiencies which cause difficulty in attracting and retaining medical care providers. Now there are 2,865 NHSC practitioners in 1,600 shortage areas, making available health care to approximately 2,280,000 people. Most of the practitioners now coming available for service are fulfilling service obligations for repayment of tuition costs paid several years ago under the NHSC scholarship program. There are also some volunteers each year.

For FY 1985 we project a field staff strength of 1,150 Federal officers and employees, plus an additional 2,433 other health professionals serving in Private Practice Option (PPO) and Private Placement (PP) assignments to fulfill scholarship obligations. These private fee-for-service practices in shortage areas accomplish the objectives of the NHSC program but do not require Federal positions.

We seek renewal of the field program, authorized under section 338 of the PHS Act. While the increase in the number of available physicians in the society will result in fewer shortage areas, there may still be areas for which this program will continue to be the only supplier of health care.

Thus, while we need to reauthorize the NHSC at reduced levels reflecting, in part, greater reliance on the PPO, we are also reviewing options to address the needs of shortage areas.

NHSC Scholarships

We are not asking for a renewal of authorization for the NHSC scholarship program (which expires this year) because the needs of the field program do not call for additional scholarships at this time. However, in the late-1980s the number of scholarship-obligated practitioners will decline, and we are developing a new, more efficient approach to meeting the personnel requirements over the next decade.

Let me move on now to the programs of the Centers for Disease Control.

Immunization Services

We are requesting reauthorization of the program of project grants for immunization services (under section 317 of the PHS Act) operated by the Centers for Disease Control. In the 21 years since grants for the childhood immunization program first were authorized, this program has been one of the most successful public health programs in the United States. Local and State health departments, working with their counterparts in the private sector, have raised immunization levels in America's children to the highest point ever and have reduced to the lowest levels ever the incidence of the diseases against which we vaccinate children. The statistics are truly encouraging: declines of greater than 99 percent have been obtained for most of these diseases and greater than 87 percent for all of them. Of children entering school for the first time in the fall of 1983, more than 95 percent presented proof of immunization against diphtheria, tetanus, pertussis, measles, rubella, mumps, and polio.

This amazing progress results from highly effective collaboration between the public and private sectors, and among local, State, and Federal governments. Federal involvement has been an important component in this progress. A Federal presence is important to deter the erosion of immunization levels and increase in disease incidence seen in the mid-1970s when Federal interest in immunization grants declined.

Experience has shown that it is often necessary to vaccinate older children and adults who may have escaped both natural infection and immunization in the past, and our hope is to include within the State and county efforts some of these persons who are at special risk. For example, in recent years more than half of rubella cases in this country have occurred in persons 15 years of age or older. Immunization of this age group is essential for the early elimination of congenital rubella syndrome.

Sexually Transmitted Diseases

We seek renewal of the program of project grants for control of sexually transmitted diseases under section 318 of the PHS Act. This program too is a fine example of a successful partnership between local, State, and Federal agencies. The collaborative effort is best exemplified by the gonorrhea control program begun nationally in 1972. The Federal government, with its active support, contributed to the dramatic reversal of the spiraling morbidity. By the middle of the 1970s reported gonorrhea morbidity had already begun to stabilize, and decreases became readily apparent in the 1980s, despite the growing size of the population at risk.

The case of syphilis is a bit more complicated, and it is instructive. Since Federal assistance for syphilis control began in the 1940s, reported cases of all stages of syphilis have decreased by 86 percent, and reported congenital syphilis decreased by 98 percent. To some extent, however, the national gains in gonorrhea control in the 1970s were made possible in part by diverting some resources from syphilis control efforts. While gonorrhea was stabilizing in the middle of the decade, reported syphilis cases began to increase steadily with each successive year.

Current trends warrant cautious optimism. In 1983 the number of reported cases of early infectious syphilis remained virtually unchanged compared to the corresponding number reported for 1982. These illnesses still present reasons for our continued concern. For example:

- the number of reported cases of gonorrhea and syphilis (including congenital syphilis) is still too high;
- drug resistant strains of gonococcal and other sexually transmitted organisms continue to exist and must be carefully monitored to prevent disease caused by the organisms from becoming established throughout the country;
- an increasing number of other sexually transmitted organisms, most prominently infections caused by chlamydia trachomatis, herpes simplex virus, and human papilloma virus, affect our population.

It is important not to repeat the mistakes of the past, when advances comparable to those we are now witnessing prompted us to withdraw Federal resources to support syphilis control, leading to a resurgence of the disease as a public health problem in the 1960s. The opportunity of States to make further advances in the control of sexually transmitted diseases has never been greater. Maintaining skilled professional assistance to States, localities, and other entities is part of the effective Federal response to the control of these diseases.

Health Services Research

I now want to discuss our program of health services research under sections 304, 305, and 308 of the PHS Act, carried out through the National Center for Health Services Research (NCHSR) and which we want reauthorized.

The National Center for Health Services Research is the focal point within the Federal government for research on the health care delivery system. It provides information that is used to improve the effectiveness, efficiency and distribution of health care services in this country.

In contrast with health services research programs of operating agencies, NCHSR research is designed not only to meet the needs of the Department, but those of Congress, State and local governments, and health care providers and consumers as well. To this end, the Center supports an extramural research grant program based on peer review of investigator-initiated research. It seeks to develop the knowledge base for future policies, as it did for example, in the developmental work on many key features of modern health care delivery, including these:

- the development of diagnosis-related groups (DRGs);
- the development of the Computer Stored Ambulatory Records system (COSTAR) - now the most widely used automated medical record system in the United States;
- demonstrating the value and effectiveness of nurse practitioners and physician assistants.

The Center has numerous extramural projects now under way, including one in which researchers will prospectively compare the accuracy of diagnostic predictions generated by the Duke University Corornary Artery Disease databank with the accuracy of predictions made by the patient's physician. If successful this system will enhance medicine's ability to predict the severity and prognosis of coronary artery disease.

We also have intramural research which is a steady source of timely technical assistance to Congressional committees, the Congressional Budget Office, the Department of the Treasury, and the Office of Management and Budget. NCHSR provides the basis for estimating the cost of medical care, the extent of insurance coverage, and the effects of treating employer provided health coverage as a non-taxed benefit; and has developed methods for predicting the need for long-term care.

NCHSR also operates a user liaison program to disseminate the findings of health services research projects to State and local officials, program managers, and health care coalitions.

NCHSR is also a key participant in our technology assessment activities. Our investigator-initiated extramural program includes projects to study the clinical benefits and costs of specific technologies; factors influencing technology use, dissemination and financing; and the cost and effectiveness of medical techniques.

Within NCHSR, the Office of Health Technology Assessment conducts evaluations (and coordinates those undertaken by other PHS units) of new and existing technologies for purpose of coverage determinations under Medicare. This is an activity that continues to be pertinent to the national dilemma of controlling health care costs in the Medicare program without compromising the quality of care. NCHSR is developing plans for a coordinated PHS approach for developing new approaches and methodologies for performing cost analyses, assessing new and emerging technologies, and describing the process and impacts of technology diffusion.

Health Statistics

Another essential contribution to the national health effort is our statistical program under sections 304, 306, and 308 of the PHS Act for which we seek renewal. This program is conducted by the National Center for Health Statistics (NCHS), which is the Federal Government's general purpose health statistics agency. Its data systems address the full spectrum of concerns in the health field from birth to death, including overall health status, life style, and exposure to unhealthful influences, the onset and diagnosis of illness and disability, and the use of health care and rehabilitation services.

The Center maintains over a dozen surveys that collect health information through personal interviews; physical examinations and laboratory testing; review of hospital, nursing home, and physician records; and other means. These data systems, and the analysis, public use tapes, and reports that follow from them are designed to provide information useful to a variety of users, including Congressional committees, other portions of our own Department, other Federal agencies and policy makers, and researchers in the public and private sectors and academia. One such example is the comprehensive annual report, Health, United States, recently submitted to the President and the Congress by Secretary Heckler.

I would like to provide a few examples of the important uses of NCHS data.

- As the official source of national vital statistics, NCHS provides critical information on life expectancy, infant mortality, and other indicators of our success in improving the health of our people. It also conducts in-depth studies to explore risk factors associated with infant mortality and other health problems.
- NCHS plays an important role in the government-wide National Nutrition Monitoring System, through which we are attempting to improve our understanding of the nutritional status of the population.

- The Center is conducting a special survey of the Hispanic population in the United States. For the first time this will provide a baseline to compare the health status and health care needs of this growing segment of our society with the general population.
- On an ongoing basis, NCHS provides data critical to the monitoring of our success in meeting the Nation's 1990 Objectives in health promotion and disease prevention.
- NCHS conducts a number of activities that contribute to our understanding of the aging process and the health problems associated with aging, an increasing concern as the population ages. Over the next several years, special data programs are planned by NCHS to further address this priority area.

This concludes my prepared statement. We stand ready to work with the committee on the reauthorization legislation. I would be happy to answer any questions.

The CHAIRMAN. Thank you, Dr. Brandt. We appreciate your testimony and its thoroughness, and we appreciate your summarizing it, as well.

Senator GRASSLEY. Mr. Chairman, if I could, since I have to go at 10:30, I would like to ask two questions.

The CHAIRMAN. Yes.

Senator GRASSLEY. One deals with—and also I would like to have permission to put into the record a statement that I have.

The CHAIRMAN. Without objection.

Senator GRASSLEY. First of all, I would like to compliment you on the good work you are doing as Assistant Secretary of Health, and ask you about the formula for allocation of moneys under the Alcohol, Drug Abuse and Mental Health block grant. There is a feeling among many people that this is inequitable. I am sure that you feel it is equitable.

I would like to have your comments on that, but I also want to ask if there is any possibility of review or whether maybe even a review has already been instituted by your agency.

Dr. BRANDT. Thank you very much for your kind comments, Senator Grassley.

We have looked at the allocation of block grant funds not only for the Alcohol, Drug Abuse and Mental Health block grant, but also the other two that are operational, and have prepared and submitted to the Congress a report on this particular study.

Our view is at the present time that the formula which is operational is, in fact, working. But as I say, we have presented a number of arguments and a number of alternative approaches to this in our report, which was dated September 1982. I would be pleased to give you or other members of the committee a copy of it for your perusal.

Mr. Trachtenberg may have something additional to add to that.

Mr. TRACHTENBERG. Only to say that we have done a number of computer runs, and it seems to come out that if you move away from the present method of allocation, a number of States are less satisfied with the present arrangement than are presently satisfied.

So someone gets hurt one way or the other, as we compute the different allocations.

Senator GRASSLEY. Could you generalize for me, for Members of Congress, if you had then about an equal number on both sides, people suggesting changes as opposed to those who want to maintain the status quo, or those of us that are raising the question very much in the minority?

Dr. BRANDT. Well, Senator Grassley, I really do not know whether you are in the minority or the majority with respect to the people raising the question. I think the issue is that if we changed the allocation formula in any way, there would be fairly losers and winners, if you will, with respect to the amount of dollars flowing to the States. I can assure you that none of the States that lose money would be quiet about that activity, although I anticipate those who gain probably will not say very much about it.

I think the issue, the concept of the current formula was based upon the State's receipt of categorical grant funds and, I think, was an indication therefore of the interest of the people in the State in dealing with the particular problems that were in force.

Certainly, we have received a number of recommendations about alternative formulas, and I think all of those have been considered in this report. We again are willing to work with you and the committee to look at this issue again should you desire.

Senator **Grassley**. My last question on another point is very short. How does the administration feel about the special program for women, which is included in S. 2303?

Dr. **Brandt**. Particularly with respect to the Alcohol, Drug Abuse and Mental Health block grant, I think at the present time, Senator, we still have all of these bills under review, and therefore I cannot get too specific. But I think our basic concern is that we would prefer that the States be advised of the interest of Congress and all of us on the special problems that women may present with both alcohol and drug difficulties, rather than to try to develop a new categorical program within a block grant. We would have some concerns about that as a concept. We have no concerns about certainly emphasizing the issues of women.

I have a task force on women's health that has been operating for some months now and anticipates giving me a total report on Public Health Service activities with respect to essentially an agenda for Public Health Service activities for women in the future.

One of the special things they will be addressing are alcohol and drug abuse problems among women, at least to reach them.

The **Chairman**. Thank you, Senator Grassley.

[The prepared statement of Senator Grassley follows:]

STATEMENT

SENATOR CHARLES E. GRASSLEY

BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES

February 22, 1984

MR. CHAIRMAN, THANK YOU FOR ORGANIZING THIS SERIES OF EARLY HEARINGS ON THE PUBLIC HEALTH SERVICE PROGRAMS WHICH THIS COMMITTEE IS RESPONSIBLE FOR REAUTHORIZING THIS YEAR. A QUICK START IS ESSENTIAL IF WE ARE TO GET THESE PROGRAMS REAUTHORIZED IN WHAT IS TO BE AN ABBREVIATED SESSION.

I WOULD LIKE TO CAUTION AT THE OUTSET THAT, AS WE WORK TOWARD REAUTHORIZATION OF THESE PROGRAMS WE BE MINDFUL OF THE PROBLEM WE FACE WITH FUTURE FEDERAL DEFICITS, AND EXERCISE CARE IN AUTHORIZING INCREASES IN FUNDING LEVELS FOR THESE PROGRAMS.

WITH RESPECT TO THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT WHICH WE WILL DISCUSS TODAY, I WOULD LIKE TO SAY THAT IT SEEMS TO ME THAT THE THREE BLOCK GRANT PROGRAMS, INTO WHICH WE GROUPED SOME 14 CATEGORICAL PROGRAMS IN 1981, APPEAR TO HAVE WORKED WELL, AND, IN GENERAL, I SUPPORT YOUR INTENTION TO EXTEND THESE BLOCK GRANT PROGRAMS WITHOUT MAJOR CHANGES.

I AM CONCERNED THAT THE SECRETARY, AS SHE WORKS TOWARD A MORE EQUITABLE DISTRIBUTION FORMULA FOR THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PROGRAMS, INSURE THAT RURAL STATES SUCH AS MY OWN STATE OF IOWA DO NOT SUFFER FROM ANY CHANGES WHICH MIGHT BE MADE IN THE WAY MONIES ARE ALLOCATED IN THAT PROGRAM.

FURTHERMORE, I DO SUPPORT YOUR INTEREST IN MAKING IT POSSIBLE TO IMPROVE THE COLLECTION OF PERTINENT DATA ACCROSS THE SEVERAL STATES. THIS HAS BEEN ONE OF THE WEAKNESSES IN THE BLOCK GRANT PROGRAMS AS THEY ARE PRESENTLY ORGANIZED, AND IT SEEMS TO ME THAT WHAT YOU PROPOSE IN S. 2303 WILL HELP THE STATES MOVE TOWARD A BETTER KNOWLEDGE OF WHAT THEY ARE ACCOMPLISHING, WITHOUT AT THE SAME TIME IMPOSING BURDENSOME REPORTING REQUIREMENTS.

WITH RESPECT TO HEALTH MAINTENANCE ORGANIZATIONS, I BELIEVE THAT IT IS TRUE, AS YOU POINTED OUT IN YOUR OPENING STATEMENT, THAT THEY ARE ONE OF THE MOST PROMISING AND SUCCESSFUL DEVELOPMENTS IN OUR EFFORTS TO CONTAIN THE INCREASE IN HEALTH CARE COSTS. SINCE I HEAR A GOOD DEAL ABOUT HEALTH CARE COSTS FROM MY CONSTITUENTS, I AM INTERESTED IN INSURING THAT HEALTH MAINTENANCE ORGANIZATIONS CONTINUE TO FLOURISH. I WILL SUPPORT YOUR EFFORTS TO HELP ACCOMPLISH THIS.

If I could just interrupt for a second, we will turn to Senator Eagleton, who would like to introduce one of our later witnesses. I apologize for holding you. I will have some questions for all of you.

Senator **Eagleton**. You are very kind, Mr. Chairman. I appreciate it. I will be brief.

I would like to introduce a witness that will appear in panel No. 3 later on this morning, Mr. Robert Rasmussen, president, Group Health Association of America, and executive director of Prime Health of Kansas City. Prime Health of Kansas City is, in my judgment, one of the finest HMO's in the country, and I do not think our committee could have a better witness.

I might point out one day I was visiting Prime Health. It was an icy day. I slipped and fell on the ice, and they treated me. [Laughter.]

Right there on the spot. And the price was right. [Laughter.]

So I am gratified that Mr. Rasmussen is here. I thank you, Mr. Chairman.

The **Chairman**. Well, thank you, Senator. We appreciate it.

I am just happy to greet all of you. I am sorry I was a little bit late, but I had three conflicts at the same time, which is not unusual here.

It is an honor to greet each of you, but I would like to especially express my pleasure that Dr. Mason is here. He is an old friend as well as the former director of the department of health in my own State of Utah.

Dr. Mason, this is my committee's first opportunity to congratulate you on your new post and to welcome you before this committee. We are happy to have you here.

Dr. **Mason**. Thank you, Senator Hatch.

The **Chairman**. Dr. Brandt, from your testimony it is apparent that you agree with most aspects of S. 2301, the Preventive Health Services block grant and that you support reauthorization of effective public health programs.

However, I am a little surprised that you did not comment on the new section related to home and community-based care. This is, of course, targeted for the elderly and disabled individuals at risk of institutionalization.

Would you please comment on that initiative as well?

Dr. **Brandt**. Well, I think, Senator, that the reason we did not comment on it is, as I said in my response to Senator Grassley, we have not completed our review of that particular legislation, and until we do, it actually would be premature for me to comment on it in any detail.

But we do have it under active review, and we do intend to be able to speak to that, and we will be pleased to send you our comments about it in writing when we have completed it.

The **Chairman**. All right. I would appreciate that because I have been somewhat disappointed that the studies requested in Public Law 97-414, the Orphan Drug Act, which related to home health services, have not yet been completed.

As you know, this data was due on January 1, 1984. Could you give me some indication what has been done to date and when we can expect a full report on this matter?

Dr. **Brandt**. I think Dr. Graham will be able to comment on that.

The **Chairman**. If you would, Doctor, we would appreciate that.

Dr. **Graham**. Mr. Chairman, the report was due, I believe, late last year. We have been working with the services of a contractor in gathering the data and doing some of the analysis. Unfortunately, that contractor has experienced some delays in completing the task, and it looks to us that it will be some additional 4 to 6 months delayed in reaching the results.

The **Chairman**. You are saying about April of this year to June of this year, or even later?

Dr. **Graham**. I feel that right now June is a reasonable target, since to some extent we are dependent upon the review done by the contractor.

The **Chairman**. Who is the contractor?

Dr. **Graham**. I do not know that off the top of my head.

The **Chairman**. Could you get that for me?

Dr. **Graham**. I would be happy to, Senator.

The **Chairman**. Can you give me the specific reasons why it's taking so long?

Dr. **Graham**. We will be glad to do that for the record.

The CHAIRMAN. All right. If you will do that, I would appreciate it.

Let me turn to the ADAMH block grant. What programs are currently being administered that recognize the special needs of women and substance abuse? Mr. Trachtenberg, would you care to comment on this?

Mr. TRACHTENBERG. Mr. Chairman, since the establishment of the block grant, as you know, ADAMH is no longer carrying out any services demonstration program geared to any particular group.

The CHAIRMAN. OK.

Mr. TRACHTENBERG. We are, however, continuing to do a good deal of research involving women and drugs, both from the standpoint of women and alcohol abuse and women and other drug abuse.

The CHAIRMAN. Do you feel that the Federal Government is adequately addressing the problem of women and substance abuse?

Mr. TRACHTENBERG. I think it's an area of profound proportions. I think we need to do more in terms of finding better ways to bring women into treatment, identifying those who need treatment, and assuring that those programs that are not gender-specific to women have adequate sensitivity and adequate of what women's needs are so that they can serve those people in need.

I might add that one of our recent surveys indicated that about 1,100 of the 4,000 treatment facilities that reported through the National Drug Abuse Treatment Utilization Survey indicated that they had women-specific programs even though they might have been integrated with male-oriented programs.

The CHAIRMAN. Since the block grant in 1981, what types of data collection efforts have been undertaken? Do you think that it is necessary to develop some type of national data collection effort? And if so, how would you propose to tailor that effort?

Dr. BRANDT. Mr. Chairman, I think one of the goals of the block grant program was an attempt to say to the State health officials that here are funds that can be used to address these particular problems within your State, that you should make the kinds of priority judgments and so forth that are necessary in order to meet the most pressing need.

As you know, we do not mandate reports with respect to the delivery of services from States, only that they meet Federal specifications with respect to expenditures and that they hold public hearings within their State in order to look at and be sure that public input is achieved with respect to the distribution of funds and to the priorities that have been determined by the State health officials.

So as a general statement, we have tried to follow that philosophy.

Now, with respect to the Alcohol, Drug Abuse and Mental Health block grant, I think Mr. Trachtenberg can tell you some of the specific types of information we do have.

Mr. TRACHTENBERG. Well, as Dr. Brandt stated, when we were managing the national treatment system, both in drug abuse and through the Community Mental Health Center Program and, to a lesser extent, in alcohol, it required a great deal of data on our part to appropriately manage the system and hold the State accountable and understand who was being treated and whether there were gaps in various treatment areas.

With the block grant, obviously, that has changed, and a lot of the very detailed data that we did previously collect, particularly in the alcohol/drug area is no longer being collected. But I am not sure that that is inappropriate, given the thrust, as Dr. Brandt said, to State accountability and State responsibility to determine its needs.

We do, however, collect a lot of information still. We try to be as inobtrusive as possible with the States, but we have a DON system which reviews emergency room mentions in drug abuse and alcohol. It is a nationwide program. We continue to collect data in what I mentioned before, the National Drug Abuse and Alcohol Treatment Utilization Program. We have a measure from the high school senior survey in NIDA. We have a national household survey that NIDA has also.

So there is a range of areas. We have a voluntary community mental health program through the NIMH to collect data in the mental health area, and just recently we have completed work with the National Association of State Alcohol and Drug Abuse Directors to develop a State alcohol and drug profile. The States will be using that, and that will collect common data on inpatients and treatment and funding sources. But it is not going to be as extensive as it was before, and again I do not think it needs to be as extensive.

The CHAIRMAN. Can you please identify whether or not the ADAMH block grant funds are going for services for the chronically mentally ill? And is there a need to address underserved populations to meet the unique needs of these and other groups?

Mr. TRACHTENBERG. As you know, Mr. Chairman, the legislation itself provides that the community mental health centers must give priority to the chronically mentally ill. One of my concerns prior to the block grant was that I felt that many CMHC's were not paying enough attention to this particular group.

We recently received a report from a grantee who looked at 71 community mental health centers nationwide, and it was very encouraging to see that there were increases in a large majority of those 71 CMHC's in areas very specific to the needs of the chronically mentally ill, including day treatment, residential treatment, partial hospitalization, crisis counseling, better case management. In all these areas, these have been deficits, in my opinion, in terms of many CMHC's, and we were very encouraged to see that greater expansion had occurred in that area.

Also, through our block grant annual reports that we receive and through our compliance reviews, we have found that the attention to the chronically mentally ill has been an area of very high priority.

The CHAIRMAN. Mr. Brandt, when the primary care block grant was created in 1981, critics alleged that the States would have little interest in the provision of primary care services. Now, whether or not this was true then, what experience do you have, or is there now, that the States do have an interest in these services?

Dr. **Brandt**. Well, I think the perception, Mr. Chairman, that the States did not have an interest was not correct. I think the States all along have had an interest in the provision of primary care services because that certainly is the bulwark, if you will, the cornerstone of delivering health care.

We had, in our initial development of the two health blocks, had built in, in effect, the provision of services totally around the existence of a primary care component.

The States did not respond, in my judgment, to the whole provision of—or to the acceptance of the primary care block, largely of the requirements that were quite clearly disincentives built into that block grant.

To give you some indication of the interest of the States, we have now completed the memoranda of agreement with 36 States with respect to the placement of community health centers, the respective services offered by those community health centers. We now have completed 28 such memoranda of agreement with States concerning the placement of National Health Service Corps officers to allow the States to develop their primary health care systems, in spite of the fact that we do not have a primary care block that is viable from the State's point of view.

So that in reality, we have been attempting to work with the States so that we can meet their needs by these memoranda which allow us to work with them and to decide where the community health center is best placed, to determine where priorities should be given within the State with respect to those programs and with respect to the placement of the National Health Service Corps officers.

We have been attempting to work with the States to the extent possible under the existing categorical program to allow them to integrate services because, quite frankly, from a medical standpoint you have a separate migrant health center separate from an existing primary care center, it just causes confusion and does not really make any medical sense.

It seems to me that that is why we continue to propose the primary care block that is built along medical models that are viable and that would not mandate the State to meet unreasonable expectations.

If I could just take one more moment, Mr. Chairman.

The **Chairman**. Surely.

Dr. **Brandt**. I meant to mention that Dr. Mason now lives in Atlanta and not in Utah, as well, sir.

The **Chairman**. Well, we miss him in Utah, but we are delighted, too, that he is there in Atlanta on that job.

Dr. Mason, what is the background—let me turn to you—to the Department's proposal for a campaign to eliminate rubella? Specifically, has the number of new cases of rubella increased recently? What is the Department currently doing to eliminate and reduce the number of cases of rubella?

Dr. **Mason**. Mr. Chairman, Dr. Brandt commented earlier that this Nation, through Federal, State, and local partnership and working the public and private sector together, has achieved this magnificent level of immunization for school enterers. Around 95 percent of these children are immunized against rubella and these other vaccine-preventable diseases.

However, rubella vaccine has not been around as long as some of the others. So we find in our childbearing women 10 to 20 percent of these have neither been immunized against rubella or had natural infection. So here today, when we have an effective vaccine, we are still having somewhere between 90 and 110 babies born each year with congenital rubella syndrome.

Now, each one of these babies could be severely handicapped, and it might cost as much during the lifespan of that baby, apart from the heart throbs of that unnecessary waste, as much as a quarter of a million dollars for institutional care.

So what we are planning to do, as Dr. Brandt outlined, is to tailor-make immunization programs to specifically get to these high-risk women who still are susceptible to this infection that is so devastating to their unborn infants. And so the program is to get older people of childbearing age who still may be susceptible to this disease, and we will want to work closely with the States to target those populations where we have large numbers of susceptible women.

The CHAIRMAN. Well, thank you. I would like to give you some credit, Dr. Mason. I just noticed the UPI story yesterday that patients in Utah's hospitals continue to have the shortest length of stay anywhere in the country, contributing to a lower overall average hospital charge than most areas of the country.

The average length of stay in Utah hospitals in 1982 was 5.4 days compared with an average in the Rocky Mountain States of 6.6 days and nationally of 7.6, according to a study by the American Hospital Association and the Utah Hospital Association.

I attribute a lot of that to the leadership that you provided in Utah, Dr. Mason, and we are hopeful that you will continue to provide that great leadership in your present job as well. I am sure you will. We are glad to have you at CDC.

Dr. Brandt, let me come back to you. I would like to turn your attention for a moment to the new development of social HMO's that provides, through the HMO, a structure of a wide range of services that are vital to the elderly from medicare to home care and community services.

As you know, I expressed my interest in this idea in a letter last month to David Stockman, supporting demonstration projects which the Department plans to conduct through Brandeis University to test the feasibility of social HMO's.

Could you give us a status report on this promising development?

Dr. BRANDT. Let me let Dr. Graham address that.

The CHAIRMAN. All right. Dr. Graham.

Dr. GRAHAM. Mr. Chairman, we have relatively limited information within the agency about the Brandeis study or the potential for social HMO's. At the present time, the major responsibility for investigating the possible utility of the social HMO resides with the Health Care Financing Administration. I believe it is HCFA that will be participating most directly with the people at Brandeis or any other place that such studies may be developed.

For the record, we can try to work with HCFA staff and to provide you with the most up-to-date information as to where their study stands at the present time.

The **Chairman**. Dr. Brandt, a question for you and perhaps Dr. Graham and Dr. Marshall. I understand that the user's liaison service in the National Center for Health Services Research is particularly valuable for the States. Could you just tell us a little bit about your plans for this program?

Dr. **Marshall**. Well, the user liaison program represents an effort to try to translate research results which normally are written for the benefit of other researchers into the kind of information that is useful to State and local policymakers who have to make decisions in real time about limited resources. Basically, it focuses on people who work in the executive offices of Governors and people in State legislatures who are making these kinds of decisions.

What we do is, working with what we feel are representative panels of these types of individuals, identify issues where we then put together a group of researchers to come together with a group of potential users and try to translate the research results into the kinds of information that is germane to issues that they are dealing with in their States.

Examples of things that we either have done or are working on now include cost containment, which is a very, very hot issue for a lot of State legislatures, viability of rural hospitals, the use of health maintenance organizations and what they can contribute to an overall State activity.

So we will plan to continue those activities in the Center in the coming years because it is an important part of our activity.

The **Chairman**. Thank you.

I will at this time, without objection, put the UPI story that I mentioned about Utah in the record.

[Material supplied for the record follows:]

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Utahns have shortest hospital stays

SALT LAKE CITY (UPI) _ Patients in Utah hospitals continue to have the shortest length of stay anywhere in the country, contributing to a lower overall average hospital charge than most areas of the country.

The average length of stay in Utah hospitals in 1982 was 5.4 days, compared with an average in Rocky Mountain states of 6.6 days and nationally of 7.6, a study by the American Hospital Association and the Utah Hospital Association shows.

In 1982, Utah hospitals averaged $2,038 per admission, compared with a regional average of $2,300 and $2,500 for the United States.

Utah hospitals also recorded a 15.8 percent increase in costs over 1981, Nationally, the increase was 15.2 percent.

Utah's low median age of 24.2 years is a factor in the lower rate of hospital admissions, Utah Hospital Association spokesman Robert Burton said.

The median age nationally is 30 years, with most medical expenses incurred in very early or late years of life, he said.

In 1982, 131.7 out of very 1,000 Utahns spent some time in a hospital. The state ranks 50th in the number of beds per 1,000 population. Only Alaska was lower in a survey that included the District of Columbia.

Utah ranked 37th in expenses per admission.

The amount of uncompensated care per admission in Utah hospitals increased more than $10 million in 1982, reaching $64.9 million.

That category includes bad debt, charity care and the shortfall in reimbursement by government programs that do not pay the full cost of hospitalization.

Patients who pay their own bills or are covered by private insurance are charged the difference for those patients who don't pay the full amount. That adds $83 a day to the bills of non-government patients, the Utah association says.

Hospitals and doctors attempting to reduce the rate that prices are increasing have encouraged patients to seek care outside of hospitals, the association says.

From 1981 to 1982, the number of patients who visited hospitals but did not stay overnight increased 40 percent, while surgeries that required a patient to remain decreased 5.5 percent.

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n.m.

PAGE, Ariz. (UPI) _ Two New Mexico children have been killed whil

The **Chairman**. I would also submit written questions to all of you so that you can answer those, if you could, as quickly as you can.

I would also note that Senator Kennedy could not be at this hearing today due to a schedule conflict. So I convey his regrets, and I would like to submit for the record questions that I would like you to answer for him later.

I appreciate the time that you have given. I appreciate the good testimony you have given and having all of you gentlemen here with us.

With that, what I think we will do is recess for 5 minutes, and then we will go to our second panel here today.

Dr. **Brandt**. Thank you very much.

[Recess taken.]

The **Chairman**. We will come to order. It is now my pleasure to welcome our witnesses discussing the reauthorization of the Alcohol, Drug Abuse, and Mental Health block grant. First is Russell Williams, Executive Director of Mental Health Programs for Davis County, Utah. Dr. Williams is a member of the board of directors of the National Council of Community Mental Health Centers. He brings before this committee extensive knowledge on the provision of alcohol, drug abuse, and mental health services.

Our second witness is Ken Eaton of the Office of Substance Services of the Michigan Department of Public Health. He is legislative Chairman of the National Association of State Alcohol and Drug Abuse Directors.

Both of these witnesses have a long history of working with this committee, and I want to thank them personally for being willing to share their expertise with us.

In addition, we also have prepared statements from the National Mental Health Association, the National Alliance for the Mentally Ill, and the American Lung Association, which we will put in the record. I strongly urge all my colleagues to review this testimony.

[The statements referred to above follow:]

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STATEMENT CONCERNING
THE
ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH SERVICES BLOCK GRANT AMENDMENTS OF 1984
S. 2303

PRESENTED TO THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

BY THE
NATIONAL MENTAL HEALTH ASSOCIATION

FEBRUARY 22, 1984

The National Mental Health Association urges approval of S.2303, the Alcohol and Drug Abuse and Mental Health Services Block Grant Amendments of 1984 with the important recommended changes discussed below. We commend Chairman Hatch for his early introduction of this important piece of legislation which will help assure that people in need will continue to receive appropriate mental health and substance abuse services in their local communities.

The National Mental Health Association (NMHA) is the nation's oldest and largest voluntary, non-governmental, consumer advocacy organization dedicated to the prevention of mental illness, the promotion of mental health, and the improved care and treatment of persons suffering from a mental illness. NMHA's 650 chapters and statewide divisions, and its more than one million citizen members and volunteers, work toward these goals through a wide range of activities in social action, education, advocacy, and information.

MENTAL ILLNESS IN AMERICA

The scope of mental illness in America staggers the imagination. Behind one out of every three doors is someone with some type of mental health problem. At least 35 million Americans suffer from mental and emotional disabilities which significantly interfere with their full functioning in the work place and at home. Between 2 and 4 million persons suffer from a sever mental disorder which results in a prolonged (usually life-long), sever disability. Mental illness now costs America over $40 billion a year in direct and indirect costs, with approximately $16 million being spent on the treatment of mental illnesses. Mental illnesses also accounts for more days of hospitalization each year than does any other illness, including cancer, heart and respiratory illness COMBINED!

THE FEDERAL INVESTMENT

Since 1946 and the National Mental Health Act, the federal government has performed the essential leadership role in improving the mental health of the people of the United States. The federal government has effectively and prudently exercised its leadership by conducting researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; by assisting and fostering such research activities by public and private agencies; by supporting the appropriate training of a sufficient supply of mental health professionals; and by developing, and assisting States in the use of, the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders. The positive and creative influence of the federal investment, in conjunction with the efforts of states and local governments and the private sector, has produced profound changes in opportunities for treatment, rehabilitation, and support for persons suffering from a mental illness. The century-long illusion of the "good" mental institution is being abandoned by states and communities in favor of appropriate community-based outpatient, inpatient, and support services.

As a result of the federal investment we are making impressive headway in our understanding of the human brain and its functioning. We are learning much about the close linkage between physical and mental health; about the cost implications of failing to address the mental health needs of people in a timely, humane and effective delivery system; and about effective models of "community support systems" for the 2 to 4 million persons suffering from a chronic mental disability.

We also know that people with good mental health tend to live longer and tend to have fewer diseases than people with poor mental health. We know that factors of personality and emotion are directly related to certain incidences of heart disease. Practitioners know that when mental health services are included in general health services, there is often a substantial cost offset which results from reduced utilization of medical and surgical services. We also know that the ravages of mental illness and emotional disturbance in infants and young children can be reduced or eliminated by early and enlightened treatment.

When American business addresses the need for adequate mental health services for employees, studies indicate substantial cost savings are achieved. Based on data compiled by large companies the Washington Business Group on Health concluded that the benefits of psychiatric coverage were: improved employee productivity; reduced absenteeism; improved employee morale; reduced hospital/surgical/medical utilization; and lower insurance premium.

The federal investment has also caused the creation by states and communities of nearly 800 Community Mental Health Centers (CMHCs) and has stimulated the growth of countless other community-based providers, resulting in a major shift in the mental health system from almost total reliance on a system of involuntary incarceration in public institutions to treatment in a voluntaristic and pluralistic system.

The Nation's investment, however, has not been comparable to the burden of mental illnesses. Mental illnesses continue to be the most stigmatized illnesses to which people are subjected.

A person with a mental illness, unlike most others suffering from an illness or disability, will be denied equal access to many federal programs, as well as most private health insurance programs. Many federal government programs, such as Medicare, Medicaid, and the Federal Employees Health Benefits Program, specifically discriminate against people suffering from a mental illness. Other programs, such as housing, education, and disability insurance, discriminate on a de facto basis. Private health insurance illogically limits mental benefits and discourages utilization of cost-effective non-hospital alternatives to treatment.

These discriminatory policies and practices result in higher health care costs (much of which the federal government will eventually have to pay), reduced worker productivity, and further stigmatization of persons with a mental illness.

The federal government's health research policies also reflect this pervasive stigmatization of mental illness. While there are approximately 35 million cases of mental illness a year (more than cancer, diabetes , kidney and neurology conditions combined), the amount spent on mental health research in terms of per case of illness is only Five Dollars ($5.00) per case. This is compared with $168 cancer research dollars per case of cancer; $16 diabetes research dollar per case of diabetes; and $10 research dollars per case of kidney and neurology conditions. This gross disparity in research effort is compounded by the reality that only 15 percent of the funds that support research in the mental health arena are provided by non-government sources, while in other areas of medicine the amount is closer to 45 percent.

Federal, state, and private sector policies as to treatment also reflect this discriminatory attitude toward persons with a mental illness. Investigators have consistently shown non-hospital alternatives to be as good or better than hospitalization for seriously disturbed patients, and usually cheaper; however, 70 percent of all mental health dollars are spent on inpatient care, and 25 to 30 percent of all hospital dyas are for mental disorder. As the New England Journal of Medicine recently reported, patients with serious psychiatric disorders are often not treated in ways that have been shown to be the most effective and least expensive. One of the major reasons for this is the lack of public and private health insurance coverage for non-hospital treatment. Another major reason is the failure of consistency in federal policies. On the one hand, the ADM Block Grant and the policies of the National Institute of Mental Health (NIMH) encourage community-based treatment and support services with hospitalization only when necessary and appropriate; while on the other hand, the reimbursement policies of the public programs such as Medicare and Medicaid, and the private health insurance programs favor hospitalization, even when non-hospital alternatives are more effective and less expensive.

The funding history of the ADM Block Grant also reflects the stigmatization of mental illness, as we will discuss below.

REAUTHORIZATION OF ADM BLOCK GRANT

In 1981 the Alcohol and Drug Abuse and Mental Health Block Grant was established to continue the federal government's support of mental health and substance abuse Services under a new authority which consolidated all mental health and substance abuse service programs into a single grant to be administrated by the States. The ADM Block Grant is essentially two block grants programs within one authority, with different requirements and provisions for substance abuse programs and mental health services. Nationally, approximately 48% of the total appropriation goes to states for community mental health services. The ADM Block Grant is the only federal mental health services program that encourages the development and maintenance of community-based services which respond to local needs. Over the past 3 years this block grant has assured the identity and continuance of community mental health centers, and has focused national attention on those population groups who are most in need. The ADM Block Grant should be continued so as to allow states and community mental health centers and other providers to have the flexibility to meet local needs.

The proposed funding levels in S. 2303 beginning in FY 1985 at the President's requested funding level with a 3 percent increase in each of the out-years, however, continues the stigmatization of mental illness and would prevent Congress from responding again as it did last year to increased service needs. The National Mental Health Association recommends the funding levels be not less than the following, which provide for a continuance of the FY 1984 funding level in FY 1985, with a 3 percent increase in the out-years:

FY 1985	$532.0 million
FY 1986	$548.0 million
FY 1987	$564.4 million

Under the Omnibus Reconciliation Act of 1981 the FY 1982, FY 1983, and FY 1984 fundings levels for the block grants were intended to be appropriation levels. This expectation has become closer to a reality for the other social services and health block grants than it has been for the ADM Block Grant as the following chart shows:

(in millions)

	FY 1984 Authorization	FY 1984 Appropriation	Appropriation As % Of Authorization
Social Service Block Grant	$2,500.0*	$2,675.0	107%*
Maternal & Child Health Care Block Grant	$ 373.0*	$ 399.0	107%*
Primary Care Block Grant	$ 327.0	$ 327.0	100%
Preventive Health & Health Services Block Grant	$ 98.5	$ 88.2	90%
Alcohol and Drug Abuse & Mental Health Block Grant	$ 532.0	$ 462.0	87%

*Authorizations for Social Services & the Maternal and Child Health Care Block Grants were increased so as to allow for the increased appropriations.

During each of the three years of the ADM Block Grant the appropriations for this program have been substantially less than the intended appropriation, as is shown in the following chart:

(in millions)

	FY 1981	FY 1982	FY 1983	FY 1984
Authorization	--	$491.0	$511.0	$532.0
Appropriation	$638.0*	$432.0	$469.0**	$462.0

*Appropriation prior to recessions in programs which were consolidated in the ADM Block Grant.

**Includes $30 million supplemental appropriation in "Jobs Bill" to respond to increased demand for services caused by rising unemployment.

Thus, the funding of the ADM Block Grant began its inauspicious history with a 32% cut in FY 1982 from the equivalent FY 1981 appropriations, which represented only 88% of the authorization level of $491 million. Then in FY 1983 the appropriation for the year began at 85% of the authorized level of $511 million, but after Congress responded in the "Jobs Bill" to the increased demand for services because of rising unemployment, the expenditures for the year ended at $469 million, a 9% increase over FY 1982. The FY 1984 appropriation of $462 is only 87% of the authorized amount of $532 million, and a 1.5% decrease from FY 1983.

The funding levels recommended by NMHA, while less than the projected rate of inflation, would permit Congress to begin to rectify the historical discrimination against mental health programs, and would allow Congress to respond to expanding needs for mental health and substance abuse services.

FORMULA ALLOCATION

NMHA supports the proposed report by the Secretary on the formula for the allocation of the block grant funds among the States. However, if the States are able to agree on a formula this year, we urge the Committee to adopt such a formula now and dispense with the proposed study.

REPORT TO CONGRESS ON ACTIVITIES

Section 8 of S. 2303 proposes to repeal the requirement for a report to Congress on the activities of the States which have received funds under the ADM Block Grant. Such information is critical in assuring appropriate use of the federal funds, and assisting Congress make decisions on the need for any appropriate changes to the legislation. We urge the Committee not to repeal this provision, but to require such reports on an annual basis.

COLLECTION OF DATA

NMHA fully supports the proposed addition to the ADM Block Grant concerning the development of model criteria and forms for the collection of data and information with respect to services provided under the ADM Block Grant. Such data collection, however, cannot be done in a vacuum. America's mental health services consist of a diversified multi-agency provider network, many of which do not receive funds under the ADM Block Grant. Data collection, therefore, in order to be useful must include data on all the services which comprise a state's mental health system. Therefore, in addition to Section 7 (b) of S. 2303, NMHA's proposal described below should be adopted.

PREVENTION PROGRAMS AND DEMONSTRATION PROJECTS

Prevention programs in the fields of mental health and substance abuse have been sorely neglected. This bill, S. 2303, will help address the needed prevention programs that are effective in reducing the ill health effects of substance abuse among women. A similar initiative is needed to help address the needed programs to prevent mental illness and promote mental health.

With the assistance of NIMH's Office of Prevention there has developed a body of knowledge and applicable technology in effective programs to prevent mental illness and promote mental health. The critical problem now, in addition to continued prevention research, is disseminating the information and implementing programs that work.

The National Mental Health Association, therefore recommends a new authority be added to S. 2303 providing funding of not less than $10 million for mental health prevention, with not less than inflationary increases in the out-years. These funds would be allocated to the states to establish or to supplment a state-level Office of Prevention within the state's mental health authority. Such offices would implement, stimulate, and coordinate primary prevention and promotion activities, i.e., service programs, information-sharing, training, development of materials designed to prevent mental or emotional disabilities in groups that are at risk for such disorders or to enhance the mental health of the general population. Such offices should be encouraged to establish linkages to prevention programs in other state departments concerned, for example, with prevention of drug or alcohol abuse, child abuse, spouse abuse, or delinquency. The funding of $10 million would allow an allocation of $200,000 to each state.

This bill, S. 2302, should also be amended to add an authority for demonstration and evaluation projects, as well as comprehensive data collection and dissemination by the National Institute of Mental Health. This authority is needed to reverse the errosion of these essential and historical roles of NIMH over the past several years. This new authority should provide sufficient funding in addition to that for the ADM Block Grant for service demonstration such as NIMH's highly successful Community Support Programs, and for comprehensive data collection and dissemination, as well as technical assistance.

The National Alliance for the Mentally Ill
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TESTIMONY

ON THE REAUTHORIZATION

OF THE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH BLOCK GRANT

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBMITTED BY

THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

February 22, 1984

Mr. Chairman and Members of the Committee:

This testimony represents the position of the Board of Directors of The National Alliance for the Mentally Ill, a four year old organization, consisting of family members -- parents, spouses, siblings, children -- and friends of individuals with disabling mental illnesses -- the schizophrenias and affective or manic depressive disorders.

We are a self-help organization whose members have come out of the closet to advocate for the seriously mentally ill who are unable to speak on their own behalf. The National Alliance for the Mentally Ill has 270 affiliates in 47 states and we are growing rapidly having doubled our affiliate membership in the past 18 months.

As this Committee knows, the serious mental illnesses -- the schizophrenias and serious depressions strike 10 million people in our country. An additional 30 million immediate family members are impacted by these disorders -- by repeated crises including hospitalizations, suicides, inability to maintain jobs in competitive settings, and difficulties in relationships.

Of the total hospital beds in our nation, more are occupied by the mentally ill than those with any other illness. These diseases can last for the life of the person, and cripple the individual's capacity to be self-sustaining vocationally and socially. With proper treatment however, the symptoms can be controlled and with support many victims can achieve a degree of independence.

In what follows, we suggest some ways in which the ADAMHA Block Grant Program can be revised to provide proper treatment and support for these victims of mental illnesses.

Last year NAMI testified before the appropriations committees in support of this program and suggested gently to the Congress that it put pressure on recipients of these grants to ensure that they comply with the intent of Congress which is to emphasize care of the chronically mentally ill. Since that time, our office has talked with hundreds of mentally ill people and their families across this nation about the performance of the Community Mental Health Centers which are the mechanism prescribed in law for using these funds. The message we hear from our people is clear and urgent: with some important exceptions, the CMHC's are not helping the people Congress intended them to help -- the chronically mentally ill.

There seem to be two reasons for this. First, it is difficult to effect a cure for mental illness. By contrast, people suffering from bereavement or anxieties often recover completely. Hence some CMHC psychiatrists, psychologist, and social workers prefer to treat people with emotional problems rather than those suffering from mental illness. Secondly, the method of operation practiced by many CMHC's is not well suited to the needs of the chronically mentally ill. They tend to work from 9 to 5 Monday through Friday, and to have waiting lists and time consuming evaluation procedures, whereas mentally ill people often need help at odd hours and on short notice. Moreover, our members report that many CMHC's feature what we call "talk therapy" which is not of much use to most mentally ill persons by itself although counselling on practical problems is useful especially in combination with a program of prescribed medications.

After hearing from so many persons that CMHC's are not doing much for the chronically mentally ill, it was surprising to re-read the intent of Congress which is that the CMHC's should give "special attention to individuals who are chronically mentally ill." It is a fact that in many jurisdictions congressional intention is not being carried out. Hence one change we urge you to make is to eliminate the requirement that states should channel ADAMHA Block Grant money through CMHC's as the instrument of first choice. In some cases CMHC's are doing a good job and states should be free to continue to channel Block Grant funds through them. In many other states, CMHC's are not doing the job and states should be free to find other programs that can do a better job of carrying out the will of Congress.

Considerable progress has been made in recent years in identifying the kinds of community-based support needed by chronically mentally ill people. This is thanks in large part to the insightful actions of Congress in providing from $4 to $7 million annually between 1978 and the present for the NIMH-administered Community Support Program. This has been a pilot program to test and demonstrate the effectiveness of various support programs based in the community. For less that $40 million over the past 5 years this program has been a resounding success -- a sound, pragmatic approach to the needs of the chronically mentally ill.

And what have we learned about those needs from this pioneering effort? A comprehensive community based program to help the chronically mentally ill achieve as much independence as possible and to reduce the painful and costly rotation of patients in and out of hospitals, should contain these elements:

1. A place to live that teaches the skills needed for independent living.
2. A program of constructive activity during the daytime such as training or low-stress jobs.
3. A network of friends to turn to when lonely or in need of emotional support.
4. Medical treatment for the mental illness including crises intervention as well as treatment for dental and other medical problems.
5. Income to pay for the above.
6. Help in dealing with the many complex governmental agencies handling the above matters.

It would make sense for the Congress to make block grant funds available for any of these elements of a community support program through whichever agencies can serve the purpose best as determined by each state.

In addition to permitting states to choose the agencies to administer these funds, we recommend the Congress reinforce its intention that these funds be used chiefly for the chronically mentally ill. We do not offer specific language to achieve this intent -- for example, language that would prohibit its use for non-disabling emotional problems. However, the NAMI office would be pleased to work with your staff in developing language to enforce the intent of Congress.

With these two changes -- leaving states free to choose the mechanics for using these Federal funds and clarifying further the Congressional intent that the money should be used chiefly for the chronically mentally ill -- we support these block grant funds for ADAMHA.

In fact Mr. Chairman, we urge an increase to make it possible to set up a more equitable system for distributing these funds among the states without the allotment of any state being reduced. As you know, there is widespread agreement that the present formula is unfair. The chairman's bill would ask for a study of this problem by the Secretary. We are told that with an $80 million increase, one could make an equitable formula using the size of the population as the criterion without any state getting a smaller share than they presently receive. The $80 million increase could provide and added incentive for all states to set about building adequate support in the community for the chronically mentally ill. The need is certainly urgent and is likely to grow greater as the post-war baby boom comes into the 15 to 35 year age group that is most susceptible to mental illness.

One other quick point: The Administration recommends that all congressional spending mandates among the alcohol, drug abuse, and mental health programs be removed. States would be permitted full discretion in spending these funds. We hope Congress will not accede to this request. Frankly, we fear that the mentally ill -- already the most neglected of handicapped groups -- would suffer even greater neglect in many states.

The chronically mentally ill and their families are in desperate need of help. Congress has led the way before. Its intentions are clear. With the changes we have recommended, the ADAMHA Block Grant could set a realistic national standard in responding to the needs of this vulnerable group of American citizens.

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AMERICAN LUNG ASSOCIATION
The Christmas Seal People®

S. 2301, The Health Services, Preventive Health Services, and Home and Community Based Services Act of 1984

Statement of the

American Lung Association

Committee on Labor and Human Resources
United States Senate

February 21, 1984

National Headquarters: 1740 Broadway, New York, N.Y. 10019 • James A. Swomley, Managing Director

The American Lung Association welcomes this opportunity to comment on S. 2301, "Health Services, Preventive Health Services, and Home and Community Based Services Act of 1984." The American Lung Association is this nation's oldest voluntary health agency, established in 1904 as the National Association for the Study and Prevention of Tuberculosis. The organization remains committed to its original goal--the eradication of tuberculosis--while expanding its mission to address the greater challenge of the prevention and control of all lung diseases. The primary emphasis in this statement will be justification for reauthorization of the Tuberculosis Control Program for fiscal years 1985, 1986, and 1987. A secondary empahsis will address the continued need by the chronically ill for adequate home health care services.

Tuberculosis Control Program

Tuberculosis is an infectious disease which can be transmitted without regard to geographic or governmental boundaries. It is a public health problem of national scope and its prevention and control require a national commitment.

Due to advances in medical sciences, tuberculosis is preventable and curable when treated with appropriate drugs. The drugs are inexpensive and hospitalization is usually not required. However, drug therapy must be undergone for approximately one year. Generally local health departments have the responsibility for locating individuals with tuberculosis and ensuring that they complete drug therapy. A further responsibility is the identification of persons in contact with individuals diagnosed with TB in order to begin preventive therapy if so indicated.

During the past 25 years, the number of reported TB cases has declined by approximately 4 percent per year. In 1980, however, the rate increased by 0.6 percent, the first such increase since 1963. A major contributing factor for the increase in incidence was the large number of TB cases diagnosed in the Indochinese refugee population migrating to the United States during 1979 and 1980. In 1981 the rate declined 6 percent to 27,373 cases and in 1982 a further decline of 7 percent to 25,522 was noted. This decrease represents the anticipated rate of decline with adequately functioning TB control programs.

Continued funding of the Tuberculosis Control Program will enable the Centers for Disease Control to address several specific proglems which remain in the control and prevention of tuberculosis.

- o Drug Resistant Tuberculosis is a continuing problem for many health departments. Approximately 7 percent of new cases (previously untreated cases) are found to have been caused by drug resistant tuberculosis bacteria. There have been 3 community outbreaks of drug resistant tuberculosis--Mississippi, New York, and Montana. Therapy for drug resistant TB presents a more complex treatment problem. The drugs used are more toxic and less effective creating patient compliance problems which require a significant increase in the surveillance activities of health department out-reach workers.

o Tuberculosis in Children, which is an indicator of on-going transmission in a community, has shown no decline in the period 1976-1982. Only about 30 percent of children who are contacts to new cases are placed on preventive therapy. This population is considered a primary priority for preventive therapy since they are at highest risk of developing TB. Further, preventive therapy for children does not present the compliance problems of other populations since children do not experience any side effects to the drug therapy. Improved case-finding and improved surveillance and assessment activities by outreach workers could increase the percentage of children (who are contacts to new cases) placed on and completing preventive therapy.

o Examination of Contacts and Completion of Preventive Therapy continues to be a problem. Annually, approximately 10,000 contacts of new cases are not identified. 5 to 10 percent of these contacts can be expected to subsequently develop infectious TB. Over 30 percent of persons placed on preventive therapy fail to complete the recommended regimen--18,000 persons annually. As a result, 900 to 1,800

> of these persons, even though examined and placed on preventive therapy, will eventually develop infectious disease. Improved case-reporting and disease surveillannce and additional out-reach workers who directly observe therapy could accelerate the reduction of transmission of disease from this group and avoid unnecessary hospitalizations.

The continued funding of the Tuberculosis Control Program at the levels authorized in S. 2301 of $8, 9, and 10 million respectively for fiscal years 1985, 1986 and 1987 is essential if we are to achieve a case rate of 9 cases per 100,000 by 1990, a goal identified by an expert Task Force of the ALA in 1982. The prevention and control of tuberculosis can be achieved economically and effectively and it would be a very short-sided policy not to invest in the funds needed for its control. The cost of preventing and controlling tuberculosis falls far below the cost to society of neglecting this important health problem.

The ALA's medical section, the American Thoracic Society and the Centers for Disease Control prepared 3 important publications on the prevention and control of tuberculosis which we would like to enter into the record. The publications, "Treatment of Tuberculosis and Control of Tuberculosis", "Diagnostic Standards and Classification of Tuberculosis", and "The

Tuberculin Skin Test" outline recommendations for treatment of TB, guidelines for preventive therapy and objectives for community TB control programs.

Home Health Care Services

Our remaining remarks will address the provisions in S. 2301 which provide new authority for a home health services and community-based health services block grant. The ALA is dedicated to the identification and delivery of the best possible care for individuals with lung diseases and has taken a leadership role in communicating current knowledge of these diseases and the factors affecting patients suffering from them.

Approximately 16 million Americans suffer from one or more chronic pulmonary diseases including emphysema, chronic bronchitis, and asthma. 45 percent of patients with emphysema report restriction in their daily activities due to disease, 18 percent of patients with asthma reported such restrictions, as did 4 percent of patients with chronic bronchitis.

New knowledge that benefited respiratory patients in the hospital has not been readily accessible to patients in the home. For this, and other reasons, out-of-hospital home health care is in need of review. The general goal of home health care is to promote, maintain, or restore health and minimize the effects of illness and impaired function. The services should be given by agencies meeting appropriate standards, and should help recipients achieve and sustain an optimum level of health, activity, and independence. The services may be therapeutic or preventive. The purpose of home care should be the provision of direct patient services, treatment, education or evaluation.

Health care within the home for both adult and pediatric respiratory patients have been impaired because of many deficits. There is the lack of individuals educated in the specific needs of respiratory patients in the home, lack of adequate home care services, lack of effective coordination of these services, limitations in financial coverage, and regional variability of coverage.

Unique problems arise in the allocation of home health care services for children with chronic pulmonary diseases. Asthma and cystic fibrosis are the major causes of school absenteeism and disability for children under 17 years of age.

For the respiratory disease patient, the home health care team, optimally, should be composed of physicians, both primary care as well as specialists in pulmonary medicine; respiratory nurse specialists and nursing personnel at all levels; psychologists; social service personnel; physical therapists; occupational therapists; respiratory therapists and technicians;

vocational counselors; nutritionists; homemakers; and home health aides.

Direct services may, but need not always, incude such services as physical training, energy conservation measures, bronchial hygiene, breathing exercises, psychological and vocational counseling, nutrition education, equipment management and monitoring, personal care, housekeeping or homemaker services, transportation, meal preparation or provision, financial support or planning and escort service.

Not all home patients need all services, and many needed services are unavailable. Patients' disease processes, for example, may be "stable" but require basic supportive services such as chest therapy. Chronic periods may be marked by exacerbations requiring even more supportive services, such as oxygen, assistance with ambulation, or dietary changes.

The ALA supports efforts to expand home health care services to the disabled and elderly. This population should include respiratory disease patients and of particular importance, the unstable patient with recurrent cardio-pulmonary deterioration. The ALA believes the needs of many patients with chronic respiratory disease could be better met in the comfort of their homes instead of resorting to institutional care. However, the comprehensive needs of of respiratory patients must be met if home health care is to be a viable alternative to institutional care.

To ensure proper care and treatment of patients in the home, standards should be established for health professionals and all personnel providing home health care services. Inclusion of standards should be part of the certification process of all agencies providing home health care services.

Thank you for this opportunity to present our views.

The CHAIRMAN. Dr. Williams, we are very happy to have you with us. We are proud of the work that you do, and it is a particular honor to welcome both you and Mr. Eaton to this committee. We will start with you.

STATEMENT OF RUSSELL WILLIAMS, EXECUTIVE DIRECTOR, DAVIS COUNTY MENTAL HEALTH CENTER, FARMINGTON, UTAH; ACCOMPANIED BY KENNETH L. EATON, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

Dr. WILLIAMS. Thank you. Mr. Chairman and members of the committee, I am here today to present the views of the National Council of Community Mental Health Centers with respect to S. 2303, the alcohol, drug abuse and mental health block grant reauthorization bill. I might mention that I deem it an honor and a privilege to be able to represent the National Council of Community Mental Health Centers at this hearing.

Mr. Chairman, Utah has demonstrated its concern and commitment to the residents of the State of Utah by addressing the needs of those who are experiencing alcohol and drug addiction and mental illness by establishing a comprehensive community mental health system, including the Utah State Hospital. The Utah system has not only addressed the needs of those who are disabled, but has also been conscientious of the residents of the State of Utah through the development of a program which is in harmony with the conservative fiscal policies of the State of Utah.

Within the State, Federal, and local partnership, Utah has developed a statewide comprehensive mental health system that is directly available to 95 percent of its residents, compared to 86 percent availability within region VIII and just over 50 percent availability nationally.

Utah prides itself on its ability to provide comprehensive community mental health services to 95 percent of its residents at a per capita cost that ranks at 50th among the 51 States and the District of Columbia.

In 1979, Utah became the first State in the Nation to expend a larger portion of its available alcohol and drug and mental health resources for community-based programs than for institutional care.

Mr. Chairman, I would like to point out that the community mental health system is working, and as evidenced in the State of Utah, works well in helping to provide services to those in need.

The National Council of Community Mental Health Centers represents over 600 community mental health programs. Community and comprehensive mental health programs are designed to provide treatment with the major emphasis on providing services to the mentally ill at the local level.

Through programs such as these, the majority of our Nation's citizens have access to comprehensive mental health services that would not otherwise be available to them, in a setting that offers the clients an opportunity to remain in the community with family and friends, at a lower cost than in institutional care.

Revenues for community mental health services flow from many sources, including the ADM block grant, State government, local government, medicare, medicaid, private insurer, patient fees, and contributions. According to a recent national council survey, the four major sources of funding for community mental health center activities are: State government, 38.6 percent; local government, 16.1 percent; the ADM block grant, 13.6 percent; and collections, 31.7 percent.

According to a recent survey of the national council members, the majority of reporting centers provide the following services: inpatient, outpatient, day treatment, 24-hour emergency, alcohol and drug abuse, transitional residential, consultation/education, screening evaluation, aftercare, and prevention.

The national council views the ADM block grant as a foundation of funding for community mental health services which helps forge a partnership among Federal and State governments and community mental health centers.

It is our position that the ADM block grant should provide a long-term, stable Federal funding floor to support the ongoing activities of community mental health centers. Although community mental health center funding comes from a myriad of sources, the ADM block grant remains the only Federal program with the sole focus of funding community mental health services.

Mr. Chairman, the council applauds your bill, S. 2303, because it embraces the fundamental objectives and goals that the national council views as necessary for extending alcohol, drug abuse, and mental health services to those in need. S. 2303 assures stability to a proven and effective program by extending the ADM block grant for 3 years, assures growth through increased authorization levels, and assures a continuing Federal commitment for the funding of community mental health services.

Although the national council certainly embraces the chairman's bill, a major issue related to the allocation of ADM block grant funds also needs to be addressed.

During the January 1984 National Council of Community Mental Health Centers Board of Directors meeting, the Board unanimously approved a recommendation for changing the ADM block grant funding formula. The details of the national council's recommendations are described in my written statement.

Of course, Mr. Chairman, the national council would like to see a new formula based on the concepts outlined in the written statement enacted into law as soon as possible. We want you to know that we stand ready to assist and would like to participate with the committee in developing such a formula.

However, if the formula is not going to be altered in this reauthorization, we would appreciate your willingness to consider changing the funding formula report deadline to November 1985 in order to reduce uncertainty among a number of States and so that States can depend on at least an annual cycle of stable funding.

At this point, Mr. Chairman, I would like to address four final items regarding S. 2303.

First, I would like to address the proposed authorization levels in S. 2303. Although the proposed bill allows for growth over the next 3 years, the proposed 1987 authorization levels would still fall below the current fiscal year 1984 authorization level of $532 million. Moreover, we are concerned that the proposed authorization levels, which represent only a 9-percent increase over the next 3 years, will not allow for maintaining the current service levels, much less allow for services to be extended to unserved areas or to expand to meet the unmet needs of the mentally ill in our communities.

Therefore, we would urge the committee to raise the authorization levels in S. 2303.

Second, the national council endorses the data collection provision in S. 2303. We are especially pleased that the data collection tool would be developed with the input of all concerned parties.

Third, the national council welcomes the proposed separate authorization in S. 2303 for a special demonstration for the prevention and treatment of alcoholism, alcohol abuse and drug abuse among women. As you, Mr. Chairman, have clearly pointed out, alcoholism and drug abuse among women is a rapidly growing problem in our society, and we need to develop programs to meet the unique needs of this underserved population.

This demonstration provision represents an important step, but there are other groups, for one reason or another, who are not able to access the alcohol, drug abuse and mental health system, and we need special programs developed for them also.

The national council would suggest to the committee that consideration be given to establishing other separate demonstration initiatives outside of the ADM block grant for these other underserved populations and to provide for the development of alcohol, drug abuse and mental health services to those in need in areas where these services are inadequate or nonexistent.

Fourth, in order to assure maximizing the utilization of ADM block grant revenue for direct clinical services, the committee is requested to evaluate the need to continue the administrative allowance provision at the current 10-percent level.

In addition, the national council urges the committee to restate the current provisions of the law prohibiting States from supplanting State revenue with ADM funds and also from supplanting funds already obligated to community mental health centers to complete the 8-year start-up cycle.

Finally, it is recommended that the committee reiterate that community mental health centers, at a minimum, continue to provide the comprehensive range of services as described in existing law.

In closing, Mr. Chairman, the national council appreciates your ongoing leadership and support in the fields of mental health, alcoholism, and drug abuse. We are pleased to have had this opportunity to appear before you today and look forward to continuing to work with the committee in obtaining early favorable action on S. 2303.

At this time I would like to entertain any questions that you may have.

[The prepared statement of Dr. Williams and responses to questions submitted by Senators Hatch and Grassley follow:]

NATIONAL
COUNCIL OF
COMMUNITY
MENTAL
HEALTH
CENTERS

STATEMENT ON

S.2303, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT REAUTHORIZATION

Presented by:

Russell Williams, Ph.D.
Executive Director
Davis County Mental Health Center
Farmington, Utah

On behalf of:

The National Council of Community Mental Health Centers

Before:

Labor-Human Resources Committee
U.S. Senate

February 22, 1984

6101 Montrose Road, Suite 360 Rockville, MD. 20852 (301) 984-6200

Mr. Chairman and members of the Committee, I am Russell Williams, Executive Director of the Davis County Community Mental Health Center, which is located in Farmington, Utah. I am also a member of the National Council of Community Mental Health Centers' Board of Directors and serve on the Board's Public Policy Committee. I am here today to present the views of the National Council of Community Mental Health Centers with respect to S.2303, the Alcohol, Drug Abuse, and Mental Health Block Grant reauthorization bill.

The National Council commends you, Mr. Chairman, for your timely introduction of legislation to extend the Alcohol, Drug Abuse, and Mental Health Block Grant for another three years. We especially appreciate your commitment and hard work in seeking to assure that this program is placed on sound footing and allowed to grow over the next few years.

Utah has demonstrated its concern and commitment to the residents in the State of Utah by addressing the needs of those who are experiencing alcohol and drug addiction and mental illness by establishing a comprehensive community mental health system including the Utah State Hospital. The Utah system not only addresses the needs of those who are disabled, but it has also been conscientious of the residents of the State of Utah through the development of a program which is in harmony with the conservative fiscal policies that exist in the State. Within the state, federal and local partnership, Utah has developed a statewide comprehensive community mental health system that is directly available to 95% of its residents compared to 86% availability within Region 8, and just over 50% availability nationally. Utah prides itself in its ability to provide comprehensive community mental health services to 95% of its residents at a per capita rate that ranks it 50th among the 51 states and the District of Columbia. In 1979, Utah became the first state in the nation to expend a larger proportion of its available alcohol and drug and mental health resources for community-based programs than for institutional care, thus, reinforcing Utah's commitment to provide appropriate care to the residents of the State of Utah in the least restrictive environment. By providing services in the optimal therapeutic environment, we have been able to drastically reduce institutionalization and provide appropriate services to a larger number of individuals at a reduced cost to the residents of the State of Utah. As is demonstrated in the State of Utah, the comprehensive community mental health system is working.

The National Council of Community Mental Health Centers represents over 600 community mental health programs nationwide. These programs provide needed mental health, alcoholism, and drug abuse services to people of all ages and disability groups. Community mental health programs are designed to provide comprehensive treatment with a major emphasis on providing services to the mentally ill at the local level. Through programs such as these, a majority of our nation's citizens have access to comprehensive mental health services that would not otherwise be available to them in a setting that offers the client an opportunity to remain in the community with family and friends at a lower cost than institutional care.

Revenues for community mental health services flow from many sources, including the ADM Block Grant, state governments, local governments, Medicare, Medicaid, private insurors, patient fees, and philanthropic contributions. According to a recent National Council survey, the four major sources of funding for community mental health center activities are state governments (38.6%), local governments (16.1%), the Alcohol, Drug Abuse, and Mental Health Block Grant (13.6%), and collections (31.7%). According to a recent survey of National Council members, the majority of reporting centers provide the following services: inpatient, outpatient, day treatment, 24-hour emergency, alcohol and drug abuse, transitional/residential, consultation/education, screening/evaluation, aftercare, and prevention.

The National Council views the ADM Block Grant as the foundation of funding for community mental health services which helps forge a partnership among federal and state governments and community mental health centers. It is our position that the ADM Block Grant should provide a long-term, stable, federal financial floor to support the ongoing activities of community mental health centers. Although community mental health centers' funding comes from a myriad of sources, the ADM Block Grant remains the only federal program with the sole focus on funding community mental health services.

Mr. Chairman, the National Council applauds your bill, S.2303, because it embraces the fundamental objectives and goals that the National Council views as necessary for extending alcohol, drug abuse, and mental health services to those in need. S.2303 assures stability to a proven and effective program by extending the ADM Block Grant for three years; assures growth through increasing authorization levels; and assures a continuing federal commitment for the funding of community mental health services.

Although the National Council certainly embraces the Chairman's bill, S.2303, a major issue related to the allocation of ADM Block Grant funds also needs to be addressed. As you know, Mr. Chairman, in enacting the ADM Block Grant as part of the Omnibus Reconciliation Act of 1981, Congress decided to distribute the ADM funds according to the amount of alcohol, drug abuse and mental health dollars that were in the states in 1980 and 1981. At that time, Congress intended that this funding formula would be an interim step until a formula could be developed based on some measures of "need."

During the January 1984 National Council of Community Mental Health Centers' Board of Directors meeting, the Board unanimously approved a recommendation for changing the ADM Block Grant formula. The National Council's position proposes that no state's ADM funding be reduced below the FY 84 level. Second, the position also states that all "new" money above the FY 84 level be distributed to those states that would have gained from an immediate change in a new Congressionally adopted formula. For example, a state currently receives $3.6 million from the ADM Block Grant. If for instance a new formula were to be based on 50% population and 50% per capita income, that state would gain around $4.3 million. Under the NCCMHC recommendation, all "new" money above the FY 84 level would be distributed to states like the one in this example in proportion to the amount they would have gained under the new Congressionally adopted formula. Third, the distribution of all "new" money above the FY 84 level would be distributed according to some measures of need, such as population and state revenue raising capacity. Fourth, when those states like the one described above, which would receive all "new" money above the FY 84 level, reach the total level of funding they would have gained ("maximum gain level") with an immediate change in the formula, then any additional funds above the "maximum gain level" would be distributed to all states under the new Congressionally adopted formula.

Of course, Mr. Chairman, the National Council would like to see a new formula based on the concepts just outlined enacted into law as soon as possible. We want you to know that we stand ready to assist and would like to participate with the Committee in developing such a formula. However, we understand the time constraints under which the Committee and Congress must operate during this session, and therefore, recognize the reasons why S.2303 requests the Secretary of Health and Human Services to submit to Congress a report and recommendations regarding the ADM

Block Grant funding formula by April 1, 1985. Mr. Chairman, the National Council supports your strong commitment to addressing the funding formula issue in a most timely fashion. However, if the formula is not going to be altered in this reauthorization, we would appreciate your willingness to consider changing the funding formula report deadline to November 1985 in order to reduce uncertainty among a number of states, and so that states can depend on at least an annual cycle of stable funding.

At this point, I would like to take a few minutes to discuss four final items regarding S.2303.

First, I would like to address the proposed authorization levels in S.2303. The proposed levels of funding in the bill are $472.3 million in FY 85, $486.5 million in FY 86, and $501.1 million in FY 87. Although the proposed bill allows for growth over the next three years, the proposed FY 87 authorization level would still fall $31 million below the current FY 84 authorization level of $532 million. Moreover, we are concerned that the proposed authorization levels, which represent only a 9% increase over the next three years, will not allow for maintaining the current service levels, much less allow for services to be extended to unserved areas or be expanded to meet the unmet needs of the mentally ill in our country. Therefore, we would urge the Committee to raise the authorization levels in S.2303.

Second, the National Council endorses the data collection provision included in S.2303, which requires the Secretary of Health and Human Services, in consultation with national organizations, to develop model criteria and forms for the collection of data and information with respect to services provided under the ADM Block Grant. We are especially pleased that the data collection tool would be developed with the input of all concerned parties. This process will assure that the final product would be of value to those who would use the data. Certainly we need more comprehensive information so that all of us, which includes community mental health centers, states and the federal government, can better determine the mental health needs of the general public and develop appropriate programs to meet those needs.

Third, the National Council welcomes the proposed separate authorization in S.2303 for a special demonstration for the prevention and treatment of alcoholism, alcohol abuse, and drug abuse among women. As the Chairman so clearly pointed out in his introductory statement to S.2303, alcoholism and drug abuse among women is a rapidly growing problem in our society and we need to develop programs to meet the unique needs of this underserved population. This demonstration provision represents an important step, but there are other groups, for one reason or another, who are unable to access the alcohol, drug abuse or mental health systems, and need special programs developed for them. The National Council would suggest to the Committee that consideration be given to establishing other separate demonstration initiatives outside of the ADM Block Grant for these other underserved populations and to provide for the development of alcohol, drug abuse and mental health services to those in need in areas where these services are inadquate or non-existant.

Fourth, in order to assure maximizing the utilization of ADM Block Grant revenues for direct clinical services, the Committee is requested to evaluate the need to continue the administrative allowance provision at the current 10% level. In addition, the National Council urges the Committee to restate the current provisions of the law prohibiting states from supplanting state revenue with ADM funds and also from supplanting funds already obligated to community mental health centers to complete the eight year start-up cycle. Finally, it is recommended that the Committee reiterate that community mental health centers, at a minimum, continue to provide the comprehensive range of services as described in exsiting law.

In closing, Mr. Chairman, the National Council appreciates your ongoing leadership and support in the fields of mental health, alcoholism, and drug abuse. We are pleased to have had this opportunity to appear before you today, and look forward to continuing to work with the Committee in obtaining early favorable action on S.2303.

I would be pleased to answer any questions that you have at this time.

National Council of Community Mental Health Centers

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March 28, 1984

The Honorable Orrin G. Hatch
Chairman, Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Hatch:

Please find enclosed my answers to your questions. Thank you for the opportunity to testify before the Labor and Human Resources Committee with respect to S. 2303, the Alcohol, Drug Abuse and Mental Health Block Grant. If I can be of further help, please let me know.

Sincerely,

Russell A. Williams

Russell A. Williams, Ph.D.
Board of Directors, National Council of
Community Mental Health Centers

RAW/jw

Enclosures

DR. RUSSELL WILLIAMS' ANSWERS TO QUESTIONS

Question 1.

For the most part ADAMH Block Grant funds are going to services for the chronically mentally ill. However, great care needs to be taken in pursuing the continuity of care to those suffering from mental illness. There is a tendency in some areas to use limited available resources to address the housing needs of the chronically mentally ill or to provide case management to the chronically mentally ill. Although both deserve serious consideration, treatment is of absolute necessity and without availability of comprehensiveness of services much of what has been gained in the last 20 years could be lost, such as, crisis intervention, emergency services, outpatient services to children and youth, etc. There are several underserved populations, such as, children and youth, alcohol and drug, and elderly; however, for the most part this is a function of availability of revenue not because of availability of effective programs.

Question 2.

As stated in my oral and written testimony, there are programs that exist to meet the needs of women who are experiencing alcoholism or drug abuse. However, these programs are incomplete, and I strongly support your intention as proposed in the authorization in S. 2303 to develop additional worthwhile programs for women suffering from alcoholism and drug abuse. There are specific areas, such as, identification and working through the denial system that exist for women.

Question 3.

There is an effective data collection effort being conducted at the state and local levels. Because of the uniqueness of this data, it is very difficult to develop national norms, criteria, and goals; therefore, we strongly support the data collection proposal in S. 2303. At present, it seems most reasonable that National Institute of Mental Health would be the appropriate agency to tailor this type of effort; however, it is extremely important, in our opinion, that this effort be conducted conjointly with states and with the providers of services by working through organizations that are now in place to represent them such as the National Council of Community Mental Health Centers.

Question 4.

We strongly support prevention programs and their inclusion in the basic services required under a provision of the ADAMH Block Grant. We do not feel it appropriate, however, to designate a fixed percentage to be specifically allocated to one or the other element of service.

QUESTIONS FOR MR. RUSSELL WILLIAMS, PRESIDENT, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS FROM SENATOR CHARLES E. GRASSLEY

1) I know of the good work that community mental health centers do. Dr. Mary Carman of Prairie View Community Mental Health Center in Newton, Kansas, told the Subcommittee on Aging, which I chair, at our last hearing, about the excellent program she runs there for the elderly.

   I would like to know however, how you respond to the statement made for the record by the National Alliance for the Mentally Ill to the effect that the community mental health centers are not serving the chronically mentally ill.

2) You suggested that the Committee evaluate the need to continue the administrative allowance provision of the block grant at the ten percent level.

   Is it your position that some of these funds be shifted into direct clinical services?

3) As Chairman of the Subcommittee on Aging, I am particularly interested in the welfare of the elderly and how the programs this Committee oversees affect them.

   If this Committee authorizes the new program for women in S. 2303, should elderly women be identified in the legislation as a group which should receive special attention? After all, is it not the case that elderly people use more prescription and over-the-counter drugs than other population groups, and that there is alcoholism among older people too?

DR. RUSSELL WILLIAMS' ANSWERS TO QUESTIONS

Question 1.

For the most part ADAMH Block Grant funds are going to services for the chronically mentally ill. However, great care needs to be taken in pursuing the continuity of care to those suffering from mental illness. There is a tendency in some areas to use limited available resources to address the housing needs of the chronically mentally ill or to provide case management to the chronically mentally ill. Although both deserve serious consideration, treatment is of absolute necessity and without availability of comprehensiveness of services much of what has been gained in the last 20 years could be lost, such as, crisis intervention, emergency services, outpatient services to children and youth, etc. There are several underserved populations, such as, children and youth, alcohol and drug, and elderly; however, for the most part this is a function of availability of revenue not because of availability of effective programs.

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The CHAIRMAN. Thank you, Dr. Williams. We will have Mr. Eaton testify, and then I will have some questions for both of you. Mr. Eaton.

Mr. EATON. Thank you, Mr. Chairman. I am extremely pleased to be here to share our views about proposed legislation and about the problems that still remain in the alcoholism and drug abuse area.

I cannot help but reminisce about being in a room not far from this one about 15 years ago when the United States Senate for the very first time addressed formally the problems of alcohol abuse and alcoholism. That led to legislation and eventually evolved into the issues that you are dealing with today.

It makes me as an American citizen so pleased to see the leadership of our Nation, especially our Senate, looking at these problems and dealing with them so productively. In addition to reminding you of some additional problems, I wish to point out some very good things that have happened as a result of the leadership that has come from the Senate and ultimately, from this committee.

I have taken the opportunity, by the way, to consult with several other national organizations, and in addition to representing the National Association of State Alcohol and Drug Abuse Directors, I also represent and serve as legislative chairman for the Alcohol and Drug Problems Association of North America. We have consulted about these issues with the National Federation of Parents for Drug-Free Youth, the Therapeutic Communities Association of America, the Association of Labor-Management Administrators and Consultants on Alcholism, which operates at a national level, and with the National Council on Alcoholism [NCA]. I understand you will be receiving separate testimony in written form from NCA and perhaps some others.

We do have a grim circumstance, but let me make two or three points that are very positive. In the 15 years that ensued the first inquiry by the U.S. Senate, we have seen changes in the legislation, but every single State has continued the agencies and the programs which were spawned by that early Federal legislation in the early 1970's. And their financial commitment has grown very, very dramatically. They are now in financial terms almost the senior partners of the State-Federal partnership, and though it's giving us some difficulty, I think it is working very well.

There are some signs, as we have been hearing, that drug-taking behavior of teenagers who stay in school may be beginning to change for the better. This is not yet showing up in our treatment clinics as a reduced demand for services, but it's a very promising sign. We are encouraged to see that kind of changing signal.

In the private sector, chemical dependency treatment has become a booming new part of the health care industry, and we are seeing growing instances where third-party payers—insurance companies, Blue Cross-Blue Shield—are now seeing the wisdom of making reimbursements available for chemical dependency treatment.

Volunteerism is growing as a result of these efforts. We have seen the development of new and very significant organizations at the national and local level, including the National Federation of Parents for Drug-Free Youth, many groups against drunk driving, (for example, Students Against Drunk Driving). They have made very significant contributions to our entire Nation's leadership effort. Today, compared to that circumstance of 15 years ago when you began, hundreds of thousands of Americans have now a fair shot at life because treatment services are available to them, and they can deal with their problems.

So your efforts are paying off, and the partnership is paying off. We congratulate you for your interest in continuing and commend your prompt action to renew the block grant authorities as your legislation has proposed.

There is yet another side to that coin. We still have 10 to 15 million people in this Nation who suffer from alcoholism, and more if you include drug abuse. About 33 percent of all Americans have used an illicit substance or a prescription drug for some nonmedical purpose; 76 percent of children who are abused have at least one alcoholic parent. Drunk driving crashes, as you know, have become perhaps the leading cause of death among American teenagers. Drugs are now beginning to enter that circumstance in addition to the use of alcohol.

Fully 10 percent of all of our Nation's deaths are alcohol-related, and 15 percent of the Nation's health care costs might be avoided if we could eliminate alcoholism and alcohol abuse. Much of this, in fact, can be saved by providing more treatment at earlier stages of alcoholism and by a stronger commitment to educate the American public.

We have recently seen a 33-percent increase in heroin use which leads to a hospital emergency room visit. This predominantly occurs in our cities. This is frightening, for many reasons, especially the fact that active heroin addicts each commit an estimated 350 crimes annually. Cocaine overdoses are increasing at quite a similar rate.

I will not continue to paint the grim details, because I know you have heard this, and this committee is very well aware of those kinds of problems. What I am proposing, however, is that we have a picture which says we have made a lot of progress but we have a long way to go. This is the right time for us to assess very carefully the continued nurturing of the State-Federal partnership which was begun so many years ago and continued by the block grant legislation.

A few specifics. We concur with the points that were made earlier by Dr. Williams about the allocation formula. There are some explicit inequities in the fashion with which the funds are now allocated among the States. We also concur with remarks that were made by the administration in terms of problems related to changing that allocation formula. We think the data suggested by the association represented by Dr. Williams is a very reasonable suggestion in terms of when to require a report about that allocation formula.

But I must point out that the major problem there is not a technical problem. We can find ways that most reasonable people would agree by which that allocation might be made. The big problem is that beginning from the base that we begin, the 1981 picture, there are going to be at least as many losers as there are winners, and without a significant increase in the total amount of funds which are made available if a new allocation formula is devised, I think we are going to have a great deal of acrimony among the States with any recommended change in the allocation formula because inevitably it will generate many losers as well as many winners.

The audit requirements that are recommended in the legislation are very reasonable. We think it makes sense to audit this program every 2 years instead of every year.

I must make a special point about the data collection references made in the legislation and stress that we think this is very, very badly needed. We now have an inadequate intelligence system describing what's happening around the country with respect to these problems.

I was interested to note Dr. Trachtenberg's response to some questions. I think he remains as up to date as he possibly can about these matters, and yet there were many, many issues about which he needed to plead very limited information being available to him and pointed out, as you might recall, that since the block grants the two institutes basically do not have very much information about the service delivery system, about the extent to which various groups are having their needs met, and so forth.

I think this stresses the need for some kind of uniform capacity to gather the types of information that we need as a Nation and which we can use to make policy decisions. We applaud your recognition of this need, and offer to help in any way we can with that.

We are also especially pleased with your emphasis on women in the provisions of S. 2146. We are pleased to see the special needs recognized, as you have. Those provisions I think will do two things. They will, one, help sharpen the focus that the States are able to make upon the specialized needs of women and, I hope, work them into their ongoing funded programs from block grant resources. It is obviously not going to permit them to expand to any significant degree any specialized services, but I think it is a very good start. I think the specialized research effort which you have suggested for NIDA and NIAAA is very badly needed. We certainly support that. I think there will be difficulties in terms of the resources that are recommended. I am not sure that it is an adequate effort, but it certainly is a step in the right direction. We applaud that effort.

There are some other significant needs, as Dr. Williams pointed out, that we would like you to be aware of and consider in addition to those of women. One need is the extremely serious situation which exists in many of our metropolitan areas. This is partly related to what I mentioned with respect to increased heroin addiction. For a variety of reasons, including that, our large cities are suffering an especially serious and very difficult burden. I hope we can find some way to assist them more diligently than we are able to at the current time.

The second emerging need relates to the area of drunk and drugged driving. Most States have enacted new legislation within the past year, and almost without fail, that requires additional attention and resources from the alcoholism and the drug abuse treatment community. And it is important to have widely available assessments to determine who might benefit most from a treatment setting versus incarceration or some other form of punishment from our criminal justice system.

Young people are beginning to show more and more problems in terms of demanding treatment. I think there is probably no exception to the fact that the States are seeing increased needs for treatment of young people and are faced with the circumstance in which there are inadequate resources. We are dealing with the future of our country as we look at young people, and I think it is very important that we look extremely carefully at this particular need and do what we can to respond.

In summary, I think that brings me to my final and, perhaps, most important point, and that is the authorization levels. I will not repeat the review, because I think Dr. Williams adequately reviewed the circumstance. There have been very substantial reductions since 1980 and 1981 in the total financial resources that are being provided by the Federal Government through the States. This has been managed, I think, well, and we have not suffered unduly, but we are seeing a great many effects of that.

In Michigan, we were required to lose about 10,000 patients in our treatment system as a result of the combined State cuts and the Federal cuts. And this has happened across the States.

Because of this reduction, we can look, I think, to next year, if we are not able to increase the resources beyond the level that they currently are, to more and more serious problems. We would very seriously urge the committee to look carefully at the authorization level with a view towards increasing it and at least providing the appropriations committees with an opportunity to carefully evaluate the need for additional Federal funds as they go through the appropriations process.

If we remain at such a low level of authorization, I think we shut off the opportunity to look and study that issue very carefully, and we would be happy to make specific recommendations. But clearly, I think, increases in the 10- to 12-percent range are called for and can be justified. These are investments, I think, not additional expenditures. We have some studies that indicate that for every dollar we spend in alcohol and drug abuse treatment, we get about $2 return back in the form of increased productivity and decreased governmental expenses for other programs.

The crucial issue here, I think, is the partnership, the quality of that Federal and State partnership. I think you have dealt with most of those issues. We are very pleased with, as I say, your promptness in dealing with the issues. We know the Senate calendar is extremely crowded this year and everybody is going to be involved in lots and lots of horseraces. Thank you for your leadership and your prompt action. Please count us as willing partners and collaborators as you continue the legislative process.

[The prepared statement of Mr. Eaton and responses to questions submitted by Senators Hatch and Grassley follow:]

STATEMENT OF

KENNETH L. EATON
CHAIRMAN
LEGISLATIVE COMMITTEE
NATIONAL ASSOCIATION OF STATE ALCOHOL
AND DRUG ABUSE DIRECTORS

before the

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

on

S. 2303
ALCOHOL AND DRUG ABUSE AND
MENTAL HEALTH SERVICES BLOCK GRANT AMENDMENTS
OF 1984

FEBRUARY 22, 1984

Mr. Chairman, we wish to commend you and the Committee for taking such prompt action toward reviewing the ADMS Block Grant. It demonstrates your obvious concern about this important Federal program. Please assume our continued cooperation as you proceed with the legislative process.

Extent of the Problem

The Chairman and Members of the Committee are already familiar with the range and complexity of problems which result from alcohol abuse and alcoholism, licit and illicit drug abuse and addiction. These are problems which impact on every sector of our society, transcending socioeconomic levels, race, age and sex. An estimated 10-15 million American adults are problem drinkers or alcoholics and 33 percent of all Americans over the age of 12 have used an illicit substance or a prescription drug for nonmedical purposes. American youth have the highest level of drug abuse in any industrialized nation.

No one is immune to the problems associated with alcoholism and drug abuse. Indeed, all of us have at one time or another observed the human suffering among friends, associates or family members caused by these problems. Available data suggests that alcohol abuse is responsible for 15 percent of the nation's health care costs and 10 percent of all deaths in this country are directly alcohol-related, many of them caused when young people drink and drive. Another problem associated with alcohol abuse was highlighted in a study presented at the Fifth National Conference on Child Abuse in 1981 by child abuse specialist Carol Sullivan. That study found that 76 percent of the subjects who were abused as children reported that one or both of their parents had been alcoholics. In addition, current research indicates that children of alcoholics are a high risk group in terms of developing alcohol addiction in their adult lives.

According to data obtained through the NIDA-sponsored Drug Abuse Warning Network (DAWN), the number of hospital emergency room visits as a result of heroin use increased by approximately one-third over a comparable time period for 1981; the number of cocaine overdoses reported in the first nine months of 1982 surpassed the total number of such reports for all of 1981. Sixty-six percent of high school students use an illicit substance or a prescription drug for non-medical programs before they complete high school. In addition, drug abuse has a tremendous impact on the criminal justice system and the general public as manifested by the fact that heroin addicts alone, when actively addicted, commit an estimated 350 crimes per year.

Mr. Chairman, I am pleased to appear before you and the other members of the Committee on Labor and Human Resources on behalf of the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD). NASADAD is a non-profit organization whose membership is comprised exclusively of the Directors of the officially designated State agencies responsible for alcoholism and drug abuse treatment and prevention. I will be pleased to answer any questions that the Committee wishes to pose and hope to provide as much specificity as possible with regard to the issues before us today. If, however, you require additional data, I will be more than pleased to submit any data for the record.

State Alcohol and Drug Abuse Agencies

The State Alcoholism Agencies and the Single State Agencies for Drug Abuse Prevention were initially created by the States in response to Congressional action in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, respectively, to have sole responsibility in the State to plan and administer a Statewide alcoholism and/or drug abuse prevention and treatment network. Under the Omnibus Reconciliation Act of 1981, which created the Alcohol, Drug Abuse and Mental Health Service (ADMS) Block Grant and significantly revised the role of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), the mandate for these State structures was repeated. However, I am pleased to inform you that each State has chosen to retain this State structure to effectively coordinate State alcohol and drug abuse treatment and prevention services including administration of the relevant portion of the ADMS Block Grant.

Because of the pervasiveness of alcohol and drug abuse throughout our nation, all levels of government along with the private sector must assume substantial responsibilities in the effort to prevent and treat alcohol and drug abuse and its accompanying fiscal and societal costs, including its devastating impact on individuals and families.

Federal-State-Local Partnerships

The publicly-funded alcohol and drug abuse prevention and treatment network relies on financial support from all levels of government — Federal, State and local. This partnership effort has evolved over the past two decades with the roles and responsibilities of the various government entities changing over the years. The Federal Government's initial efforts in the alcohol and drug abuse fields were to provide national leadership and to stimulate State and local government participation in the development of a well-coordinated and comprehensive alcohol and drug abuse service delivery system. At that time, State alcoholism agencies and State drug abuse agencies were generally small, had limited authority and low visibility within their State governments and State and local financial support of community based service programs was very limited with the notable exception of a few States.

With encouragement from the Federal government, however, the States soon assumed a significant portion of the responsibility for allocating and monitoring not only their own State revenues for alcohol and drug abuse services, but also for allocating and monitoring Federal dollars awarded to entities within the States for alcohol and drug-related services and programs. When the ADMS Block Grant was authorized in 1981, the States had been receiving the NIDA project grant service dollars through a mechanism similar to the Block Grant for several years — the Statewide services contract — and were already responsible for allocating and monitoring Federal monies. Also, at the time of the ADMS Block Grant authorization, Federal officials were considering switching to a

Statewide services funding mechanism for the Federal alcoholism project grants, most of which at that time were being administered by NIAAA. In fact, five States were participating in a demonstration project to test the feasibility of the Statewide services grant mechanism for alcoholism project grants. Both the alcohol and drug abuse formula grants were awarded directly to the State alcohol and drug agency, which in turn allocated the dollars where they were needed most. The States were, therefore, responsible for administering three-fourths of the programs eventually folded into the alcohol and drug portion of the ADMS Block Grant program.

Over the past twenty years, the local units of government have also assumed major responsibilities for the development of comprehensive alcohol and drug abuse programs at the community level. Major urban areas, in particular, are the site of extensive, comprehensive, publicly-funded service delivery systems which were developed to address the major alcohol and drug abuse problems which occur disproportionately in many of our large cities. City drug and alcohol coordinators, whose responsibilities are similar to the State alcohol and drug agency directors, administer these service delivery systems.

Transition from Categorical to Block Grants

When the ADMS Block Grant was authorized in 1981, the responsibilities of the Federal government for the administration of the Federal alcohol and drug abuse services programs were eased significantly. The ADMS Block Grant, authorized by P.L. 97-35, turned complete administrative responsibility for the Federal alcohol and drug abuse services dollars over to the States. Already responsible for administering three-fourths of the Federal alcohol and drug abuse programs through a mechanism similar to the ADMS Block Grant, the States were well prepared and willing to accept responsibility for awarding and monitoring the service dollars included in the ADMS Block Grant program.

The transition from categorical to block grants for the State alcohol and drug abuse agencies was smooth and did not cause disruption in services. All of the 50 States and the U.S. Territories participated in the ADMS Block Grant program during its first year —

Fiscal Year (FY) 1982 — and have continued in the program ever since with no major problems arising which relate to the ADMS Block Grant as a funding mechanism.

However, a major cause for concern and one which has hampered many States' abilities to provide alcohol and drug abuse services to those in need, has been the drastic reduction in Federal financial support which accompanied the ADMS Block Grant program. In FY 1980 (the base year for the alcohol and drug portion of the ADMS Block Grant) Federal appropriations for the alcohol and drug abuse project and formula grant programs totalled $332 million. In the current fiscal year, the alcohol and drug portion of the Block Grant equals $234.5 million — a 29.4 percent reduction from FY 1980 levels without adjusting for inflation. If the inflation rates of 10.4 percent in 1981, 6.1 percent in 1982 and 3.9 percent in 1983 are taken into account, current Federal funding levels for alcohol and drug treatment and prevention services represent a 42 percent reduction in real dollars.

S. 2303, The Alcohol, Drug Abuse and Mental Health Services Block Grant Amendments of 1984

NASADAD applauds Senator Hatch's leadership and efforts to secure a three year reauthorization of the ADMS Block Grant program as proposed by Senate bill No. 2303. We appreciate your willingness to extend the program and to seek immediate action on the proposal by the Committee. If I may, I would like to briefly describe NASADAD's support for particular aspects of the proposed legislation and to express our concern regarding the authorization levels.

Three-year Reauthorization

NASADAD concurs with the proposed three-year reauthorization of the ADMS Block Grant program. NASADAD believes that the three-year reauthorization will provide continuity and stability to the alcohol and drug abuse fields in their planning efforts. A multi-year reauthorization will enable the States to conduct long range planning activities for a stable system and will also permit the Committee to carry out complete oversight hearings without the pressures of reauthorization deadlines.

Authorization Levels

NASADAD is extremely concerned, however, over the authorization levels proposed by S. 2303 for the ADMS Block Grant program in Fiscal Years 1985 - 1987. As I mentioned previously in my statement, Federal support for alcohol and drug abuse services has been reduced by 42 percent over the past four years. States and cities are struggling to make ends meet. Many community-based programs are experiencing the phenomenon of waiting lists and of having to turn clients seeking treatment away from programs which are already operating at or above their treatment capacity. The alcoholics and drug abusers whose names appear on these waiting lists rarely return to the program a second time.

In addition, with the current emphasis on removing the intoxicated driver from our highways, the ever increasing demand for alcohol and drug services that is being placed on our urban treatment programs by clients who typically do not have sufficient means to pay for their services and the general increase in public awareness of alcohol and drug problems, our treatment and prevention programs are striving to meet demands which have never been greater, at a time when the Federal share of support for the Federal-State-Local partnership has been reduced significantly.

Because of the drastic decrease in Federal support for alcohol and drug services which was implemented in Fiscal Year 1982, NASADAD encourages the Committee to re-evaluate the authorization levels proposed in S. 2303. NASADAD realized that the current authorization level for $532 million – the ADMS Block Grant program – is significantly higher than the FY 1984 appropriation level of $462 million. However, we implore and encourage Committee members to leave sufficient room for the Congress to return Federal support for alcohol and drug abuse services to an adequate level.

As proposed, the authorized level for the ADMS Block Grant in FY 1985 would be $472 million — a two percent increase over the FY 1984 appropriation (which in itself represents a 42 percent reduction in Federal support since FY 1980). While we applaud the Committee's willingness to support an increase in the ADMS Block Grant program over the current fiscal year's appropriation, we respectfully submit that a two percent increase will result in a decrease in the purchasing power of these dollars when inflation is taken into account, as it should be.

Rather than being forced into a struggle for survival, States and cities need to be supported by the Federal government in their efforts to address the needs of alcohol and drug abusers across the country. In a survey of the NASADAD membership conducted during March, 1983 over 94 percent of the States responding reported that an unmet need for treatment and prevention services exists within their States. Thus, even though a State may be able to maintain current services levels, this is not enough — there are still thousands of individuals who need and could benefit from prevention and/or treatment services.

Recent estimates of the economic cost of alcohol and drug abuse to society have projected that the costs of alcohol and drug abuse will approach $220 billion in 1982, a figure $155 billion higher than the estimated costs for these illnesses in 1977. Given the rapidly escalating social and economic costs of alcohol and drug abuse and the current unmet need for these services in almost every State, it would appear to be appropriate for the Committee to consider increasing the authorization levels proposed by S. 2303.

Rather than increasing the Federal deficit, a sufficient commitment from the Federal government to preventing and reducing alcohol and drug abuse, would ease what is surely a significant drain on our economy. In fact, increasing the nation's treatment capacity would have a direct impact on the Federal deficit since every dollar invested in alcohol and drug treatment is returned directly in the form of increased tax revenues. At least two additional dollars are returned in the form of decreased government expenses and increased economic production.

Allocation Formula Report to Congress

NASADAD recognizes that there have been some discussions within the Congress and the alcohol, drug abuse and mental health constituencies regarding the equitability of the allocation formula for the ADMS Block Grant. As the Committee is aware, a State's ADMS Block Grant allocation is based on the amount of grants which a particular State or entity within the State received from NIAAA, NIDA or the National Institute of Mental Health (NIMH) in Fiscal Year 1980 for alcohol and drug abuse and in Fiscal Year 1981 for mental health services. While we have examined the equitability of various alternative formulas for the ADMS Block Grant allocations, NASADAD has been unable to develop a formula which would significantly improve the status of particular States without taking away from other States. We, however, are available and willing to work with the Secretary of the Department of Health and Human Services and appropriate State and local government and provider representatives in an examination of the distribution of funds allotted to the States as proposed by S. 2023.

Because of the complexity of the allocation formula issues and the need to ensure the participation of many government and provider representatives, we agree with the Committee's willingness to extend by one year the time period within which the Secretary must make her recommendations to the Congress. The legislation, as proposed, requires the Secretary to prepare and transmit a report to the Congress on this issue by April 1, 1985. NASADAD understands and concurs with your decision to extend the report due date until April 1, 1986.

Audit Requirements

NASADAD strongly supports the Senator's proposed changes in the ADMS Block Grant audit requirements, permitting States to submit their audit of Block Grant funds every two years, as opposed to the current requirement for annual reports. Since States are permitted to use the ADMS Block Grant funds over a two year period it is appropriate for an audit of those funds to also cover a two-year period.

Need for National Data Collection Activities

NASADAD believes it is crucial that a model uniform instrument and process for the collection of alcohol and drug abuse client, funding and services information be developed and we applaud the Chairman's recognition of this serious problem.

While States were previously required to report data to the Federal government as a condition of receipt of Federal funds, these requirements were eliminated with the authorization of the ADMS Block Grant. Even though States do not wish to return to the days of extensive mandated reporting requirements which collected data – the value and usefulness of which was at times questionable – the States and Institutes currently need support for the development of a mechanism and process by which significant data can be compared with other States across the nation or even within their own region.

States have become increasingly concerned over the lack of data available at the national level which comprehensively and accurately describes the treatment and prevention network and its clients. While a considerable amount of data was collected by NIAAA and NIDA prior to the beginning of Fiscal Year 1982, only limited data has been collected since that time period. In the meantime, States have sought to revise their data collection systems to make them more responsive to their individual needs. As a result, the ability of States to compare information based on the same data elements and definitions is being threatened. As responsible State officials, we believe that a uniform data collection tool and process should be jointly developed and implemented by State and Institute representatives. Some of these data elements that should be incorporated into this instrument include the following: information on total numbers of clients served by different types of programs; information on client needs, demographic characteristics and services; information on types and levels of fiscal resources utilized to support prevention, intervention and treatment services; information on emerging special needs (e.g., women, youth, drunk drivers); information on the effectiveness and impact of treatment and prevention programs.

NASADAD is willing to work with the Congress and the Secretary in whatever way we can to assist in the development of a model instrument and process which will help the alcohol and drug fields to better assess the alcohol and drug abuse service delivery systems and their clients.

Alcohol and Drug Abuse Among Women

NASADAD also wishes to express its support for the Chairman's proposals which seek to better address the needs of women. In particular, we support S. 2146, the Prevention and Treatment of Alcoholism, Alcohol Abuse and Drug Abuse Among Women Act of 1983, a portion of which is included in S. 2303.

Of the approximately 10 million alcoholics in this country it is estimated that as many as one half are females. Until the last 15 years, public agencies and professional groups paid little attention to the validity and necessity for treatment programming designed specifically to respond to the special problems of alcohol and/or drug abusing women. Although some progress has been made (some States are reporting increased participation by women in treatment programs), the majority of women with alcohol and/or drug dependency problems still do not receive or have access to services designed to meet the special needs of the female substance abusing population. There are several reasons for this phenomenon one of which is that a woman with an alcohol or other drug problem faces the double stigma of being an addict and a "fallen woman." When a woman with an alcohol or drug abuse problem begins to cope with her alcoholism or addiction she frequently faces the problem of desertion by loved ones. According to the National Council on Alcoholism, it is estimated that whereas 9 in 10 wives stay in marriages with alcoholic husbands, only 1 in 10 husbands stay in marriages with alcoholic wives. Therefore, women with alcoholism or drug abuse problems tend to experience a profound sense of isolation accompanied by feelings of guilt and shame. These feelings, along with denial of the problem, often stand in the way of women seeking help.

While several States have sought to address the often unique needs of women alcoholics and drug abusers, much work remains to be done. The State of Massachusetts has developed, with seven community agencies, several models of special programs for pregnant, drug dependent women. Also, three halfway houses exclusively for women alcoholics have been opened in Massachusetts in addition to two new co-ed halfway houses. In New Hampshire, a new halfway house for women has also been opened. NASADAD, therefore, supports the authorization of a separate program to assist the States in sharpening their focus upon prevention and treatment of alcoholism, alcohol abuse and drug abuse among women.

The limited authorization levels for this program, we feel, do not allow for any significant expansion of treatment services. It will, however, permit the States to identify and plan for needed prevention and treatment services for women.

The proposed authorization of $2 million annually for each of the Institutes to increase their efforts related to the problems of women is clearly a step in the right direction.

There are some other significant needs which we hope can be addressed in this legislation or in some other fashion. One need is the extremely serious situation which exists in many of our metropolitan areas. For a variety of reasons, dealing with alcohol and drug problems within our large cities places an especially difficult burden upon our mayors and local governments. A second emerging need relates to the area of drunk and drugged driving. As legislative and enforcement efforts have gained momentum with regard to the detection of drunk drivers, increasing demands have been placed on our treatment systems. It is important that clinical assessment and treatment resources be expanded to respond to these demands. Also, in many States, the alcohol and drug abuse treatment needs of young people appear to be increasing. The future of our nation requires that we respond with sufficient and appropriate prevention and treatment services and resources to meet the needs of our youth.

In closing, I would like to extend NASADAD's appreciation for the Chairman's leadership and in seeking reauthorization of the Alcohol, Drug Abuse and Mental Health Services Block Grant. The State Alcohol and Drug Abuse Agencies are extremely pleased with the Block Grant program and its accompanying philosophy that the States and not the Federal government are better able to identify the needs of their citizens and to determine where Federal support will be of most value.

Thank you again for the opportunity to appear before the Committee today.

NASADAD

National Association of State Alcohol and Drug Abuse Directors

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Executive Director
William Butynski, Ph.D.

April 13, 1984

The Honorable Orrin Hatch
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Hatch:

On behalf of the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) I would like to once again thank you for your strong leadership and diligent efforts during the Committee's recent consideration of S. 2303, the "Alcohol and Drug Abuse and Mental Health Amendments of 1984." I would also like to thank you for your willingness to listen to the alcohol, drug abuse and mental health constituencies' concerns and your invitation for NASADAD to appear before the Committee during your February 22nd hearing on the health block grants.

Enclosed are our responses to written questions submitted by the Committee following the February hearing. If I may be of further assistance please do not hesitate to contact me.

Sincerely,

Kenneth Eaton
Legislative Committee Chairman

Enclosure

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Question 1: From your experience as a State official combating substance abuse, what kinds of treatment programs are needed for women who abuse substances? Do women really need different services than those currently offered?

Answer: Mr. Chairman, the treatment needs of women are often more complex and at times different than those currently being served by alcohol and drug treatment programs. However, treatment programs should not be blamed since they have historically had a significantly higher proportion of men in treatment than women and thus treatment has at time tended to focus on the needs of male alcoholics and addicts. One of the major reasons for the disproportionate representation of men in treatment programs (although women represent one-half of the alcoholic and drug abusing population) is the double stigma which women with alcohol and/or drug abuse problems face in our society. Not only are women, like men, resistant to admitting they have an alcohol or drug abuse problem, but their families are quite often unwilling to accept that the wife and mother figure is addicted to alcohol or drugs since addicted women are often viewed as "fallen women." The North American Women's Commission states that it is estimated that only one in ten husbands stay in marriages with alcoholic wives whereas, nine in ten wives stay in marriages with alcoholic husbands.

Another barrier which inhibits a woman's participation in treatment programs is the belief, on her part, that she will lose her family as a result of her entry into a treatment program. A single , married or divorced mother who is told she must enter a residential treatment program for the typical 30 day detoxification and rehabilitation period is concerned about who will take care of her children while she is participating in the treatment program. If she is unable to find anyone willing to care for her children or the program cannot provide housing for the children then the woman will undoubtedly decide not to enter treatment since she cannot simply "abandon" her family.

Treatment programs for women do not necessarily need to be solely for women, but can be co-ed facilities which recognize and are sensitive to the unique, often chronic and complex needs of women. Because of the stigma attached to women alcoholics and drug addicts many of these women only enter treatment when chronic physiological and psychological problems are present. These needs must be addressed by the treatment program in addition to the alcoholism and drug addiction. Also, child care should be provided for women entering treatment and the family must be intimately involved in the treatment process. If a women with children must enter a residential program, she should be referred to a halfway house type setting as soon as possible so that she may continue to have close contact with her family on a daily basis. Job training and other services must also be provided to women if they are going to successfully reenter into the community.

Massive public education campaigns must be launched at the national, State and local levels to help ease and overcome the double stigma attached to female alcohol and drug abusers. Prevention strategies which focus on female alcohol and drug abusers must also continue to be developed and information on these distributed to the State and local levels. Families and the general public must be educated that alcoholism and drug addiction are equal opportunity diseases which do not discriminate based on sex or race.

Question 2: In current law, 20 percent of all funds allocated for alcohol and drug abuse services are to be used for prevention activities. As an advocate for prevention activities, I am always interested in learning what States are doing to prevent alcohol and drug abuse. Can you describe some of these initiatives?

Answer: In the State of Michigan we are in the process of planning the implementation of a health curriculum in the schools throughout the State which will include a major focus on alcohol and drug use by youth. We are also providing prevention training for teachers based on a Grade K-12 curriculum material developed by the State. As you may be aware, the State of Utah recently appropriated $500,000 for school-based K-12 curriculum. An additional one million dollars were dispersed to planning districts based on population. About $180,000 was allocated to provide sufficient funding to those districts where the population allocation would not provide sufficient money for minimum programming. The remaining money was held at the State level to fund media campaigns, training, evaluation of school-based programming and demonstration projects. The State of Utah has also awarded a contract to Mr. Bernell Boswell, Executive Director, Cottage Program International, who has testified before this Committee on several occasions, for a community outreach program. The goal of the program is to directly contact approximately one percent of the population of the State of Utah and to provide outreach participants with concise, consistent information about effective methods for the prevention of substance abuse.

Following is a brief, State-by-State summary which provides information on prevention activities in several other States. The information was provided by States in response to an inquiry as to whether there had been any significant changes in treatment or prevention activities. Only the responses which relate to prevention services are included.

Alabama:	VISTA volunteers, Telephone Pioneers of America, and other volunteer groups increased their efforts in promoting drug awareness and prevention programs, and in recruiting more volunteers. Additionally, the volunteer groups have joined again in sponsoring the Second Annual Governor's Conference on Drug Awareness to be held in January, 1984.
District of Columbia:	All new State-supported programs were in the area of prevention, with the primary focus on youth.
Indiana:	By policy instituted early in FY 1983, all State supported prevention programs must demonstrate direct programming on alcohol/drugs. Generic youth development/activity services are no longer supported.
Iowa:	Prevention - The expansion of service consisted of a geographical expansion, not an expansion of type(s) of services. The expansion was possible due to an increase of funding.
Kansas:	The State prevention staff initiated several major prevention training efforts in FY 1983 which will be continued. We have taken the U.S. Department of Education's School Team Training to Prevent or Reduce Alcohol and Drug Abuse design and conducted this 5-day residential training in the State of Kansas using Kansas staff. Nine 5-member teams from 5 school districts went through the first cycle. An estimated 15 teams will receive training in a June 1984 cycle. These teams impact not only their schools, but their districts and communities. An extension of school team training is Teaming the Peer Athletic Group. Kansas piloted this training for 180 high school students at one site and 175 junior high students at another site. Our parent/family initiative has shifted from formation of parent groups to training for strengthening families. 55 master trainers for Dr. Steve Glenn's Model, Developing Capable Young People, were trained and will be delivering these concepts Statewide.
Minnesota:	Some increase in community-based prevention efforts are anticipated due to the Chemical People/Minnesota project initiated in November, 1983. Some additional funds have been provided to the Minnesota Prevention Resource Center to meet the increased demand for materials and technical assistance.
Nebraska:	Funding for the Statewide Prevention Technical Assistance and Training Center (Nebraska Prevention Center for Alcohol and Drug Abuse/Nebraska Alcohol and Drug Information Clearing House) was cut by $35,000 eliminating the Nebraska curriculum revision activities.

Prevention of intoxicated driving activities were transferred to the Nebraska Office of Highway Safety, Department of Motor Vehicles. Previously these activities were co-sponsored by Office of Highway Safety and the Nebraska Division on Alcoholism and Drug Abuse;

Mini grants for $300 or less were awarded to 19 local grassroots voluntary organizations to support voluntary prevention activities;

Funding was awarded to the Statewide Voluntary Parents Movement (Parents In Action in Nebraska) to provide for coordination via a bi-monthly Statewide newsletter and materials (Parent Group Starter Kit) to support local prevention-oriented parent groups;

The Pilot of the School Community Intervention Program was initiated in Lincoln, Nebraska high schools with local private and public funds and no State support; and

The youth drug treatment program on the Omaha Indian reservation was changed to a drug/alcohol prevention program for youth. This programmatic change was requested by the program staff in response to community needs/eighteen treatment clients were referred to other agencies.

New Hampshire: On the prevention side during FY 1983, a change in targetting was a principal development. Where prior efforts were centered on community organization with adults, focus shifted towards a similar, but intensive, targetting of youth featuring promotions of peer education, peer support, and peer counseling strategies.

Oregon: Implemented prevention strategies directed at specific target populations.

Pennsylvania: Block Grant stipulations with regard to the 20% minimum to be allocated to prevention/early intervention programs resulted in a planned expansion of funding for prevention programs that doubled the number of federally funded programs for the previous year.

The first Chemical People program took place in Pittsburgh and resulted in the formation of more than 100 voluntary groups set up to participate in prevention and intervention work with the school systems. This required additional technical assistance and resource material from the State Agency.

Vermont: State employed Prevention/Intervention Specialists have been deployed Statewide (9 regions) to stimulate community organization efforts and coordinate increased prevention activities.

Question 4: In the past few years, the President, the Congress and many State Governors and State legislators have actively sought solutions to the serious problems of drunk and drugged driving. What has been the experience of State alcohol and drug prevention and treatment agencies related to these problems?

Answer: The States are pleased that appropriate recognition is being given to the myriad of problems related to drunk and drugged driving. However, increased attention and focus on these problems as well as more intensive enforcement efforts have led to greater demands on the existing alcohol and drug service delivery systems at both State and local levels. Many States and programs are finding it difficult to respond adequately to all of the increased demands and mandates for services without a corresponding increase in resources. The Block Grant mechanism has provided States with flexibility to reallocate some resources from other areas to respond to these growing needs. Nevertheless, because the demand for services is growing so fast it would be helpful if the Congress would consider providing some increased fiscal resources to assist the States in meeting these needs which range from the provision of clinical assessment and screening services to treatment and rehabilitation.

Question 5: Some national studies indicate a downturn in certain types of drug abuse among high school seniors. What is the experience of the States with regard to drug and alcohol abuse among youth?

Answer: The States are encouraged that NIDA's survey of high school seniors indicates what appears to be a downturn in the use of certain drugs such as marijuana. However, the fact that many States appear to be experiencing some increase in the demand for services by youth leads us to interpret these survey results with some caution. First of all, while there is some downturn with regard to some drugs, other drugs are continuing to be abused at high levels while some drugs (e.g., cocaine) appear to be increasing in terms of abuse levels. Also, specifically with regard to the High School Senior survey, it is important to keep in mind the limitations of the sample. It includes only high school seniors in school on the date of the survey. It does not include either high school dropouts or absentees. Also, as reported on January 5, 1984 by Secretary of Education, T.H. Bell, the dropout rate is high and increasing. Whereas, the percent of ninth graders who went on to graduate from high school was 77.2 percent in 1972, by 1982 it was only 72.8 percent. In addition, this dropout rate of over 27 percent is only the national average. In some schools, often in areas with high rates of drug abuse, the dropout rate is over 50 percent. Finally, as noted within a report on a Technical Review on Drug Abuse and Dropouts that was supported by NIDA, "Solid evidence exists to support the assumption that drug use is more prevalent among absentees and dropouts than regular students." Therefore, we recommend that caution be exercised in attempting to generalize from data collected from high school seniors to other groups.

NASADAD

National Association of State Alcohol and Drug Abuse Directors

July 26, 1984

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Jeffrey N. Kushner
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Executive Director
William Butynski, Ph.D.

Senator Charles E. Grassley
U.S. Senate
Washington, D.C. 20510

Dear Senator Grassley:

Thank you for the opportunity to submit a written response to your questions on alcohol and drug abuse which follow my testimony before the Senate Committee on Labor and Human Resources in February, 1984 on the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant. The answers to your questions which were received by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) office on July 5, are enclosed with this letter.

As Chairman of the NASADAD Legislative Committee I commend you for the interest which you have demonstrated and desire to carefully research the problems of alcohol and drug abuse, particularly as they relate to the elderly and rural areas. If you desire, NASADAD is willing and able to discuss further with you and other members of the Subcommittee on Aging the special alcohol and drug abuse prevention, education and treatment needs of the elderly and would be happy to do so at any time.

For specific information on the incidence and prevalence of alcohol and drug-related problems in the State of Iowa and the status of prevention and treatment efforts, I refer you to the Iowa State official responsible for monitoring and administering the publicly-funded treatment and prevention services network in your State – Ms. Mary Ellis of the Iowa Department of Substance Abuse. Ms. Ellis' address and telephone number are provided in the response to Question No. 2.

Also, if I can provide you with further information please do not hesitate to contact me or the NASADAD staff.

Sincerely,

Kenneth L Eaton

Kenneth Eaton
Chairman, Legislative Committee

Enclosure

444 North Capitol Street, N.W. • Suite 530 • Washington, D.C. 20001 • (202) 783-6868

Question 1: Would your organization support the proposal made by the National Council of Community Mental Health Centers here today on the changes required in the funding formula?

Answer: Our organization is unable to actively support the funding formula as proposed by the National Council of Community Mental Health Centers because the formula would benefit some of our members at the same time that it would require other members' ADMS Block Grant award to remain at its FY 1984 level for an extended period of time, without adequate adjustment for inflation. As a national association, we have chosen to support the provision included in S. 2303, the ADMS Block Grant renewal legislation which would require the Secretary of the Department of Health and Human Services to enter into an agreement with a nongovernmental entity to review the present formula for allocating funds under the block grant to determine whether a more equitable formula can be designed. The Secretary would also be required to report to Congress by October 1, 1985 on the findings of this review and to include any recommendations considered appropriate.

Question 2: You mentioned that alcohol and drug problems place a particularly heavy burden on the mayors and administrators of large cities. Could you address the question of alcohol and drug abuse in rural areas? That is, are there special problems faced by these programs in rural areas?

Answer: Alcohol and drug treatment and prevention programs in rural areas face two problems which are not typically encountered by programs in urban areas – significant transportation costs and the need for a multi-faceted services program which can address the treatment and prevention needs of many communities at the same time. Treatment in rural areas is usually provided by a centrally located service program which covers a broad geographical area. Ideally, outreach centers are located in several small towns throughout this broad geographical area. These centers might provide information services to the local community and refer clients when necessary to the treatment program. Transportation between the program and centers is a vital necessity and usually commands a sizeable portion of the program's budget. This is not a problem which cannot be overcome if sufficient financial resources are available, however. It is also interesting to note that a recent review of costs associated with programs in rural versus urban areas conducted by the Iowa Department of Substance Abuse found that the high transportation costs associated with rural programs are balanced by the high rent which programs in urban areas are required to pay.

Also, because of the broad geographical area which they must cover, rural programs must be able to provide multi-faceted services, services which will not only address the needs of adolescents involved in polydrug abuse but also services for the treatment of alcoholism in the elderly or prevention/education services to the local communities. While urban programs are often able to specialize in providing specific services to a specific population or age group, rural programs must be able to meet the unique needs of each client, whether they are 15 or 70 years of age, Black, Hispanic or White since there is often no other program in the area. Again, this is not a problem which cannot be overcome. It simply requires careful planning and evaluation and a multi-talented staff.

For a more complete picture of the alcohol and drug treatment and prevention delivery system in a rural State, I encourage you to contact Ms. Mary Ellis, Director, Iowa Department of Substance Abuse, 505 Fifth Avenue, Insurance Exchange Building, Suite 202, Des Moines, Iowa 50319, (515) 281-3641. Ms. Ellis is responsible within your State for the administration of the publicly-funded treatment and prevention services system and would be able to provide you with up-to-date information on the status of alcohol and drug abuse services in the State of Iowa.

Question 3: As you may know, I am Chairman of the Subcommittee on Aging of this Committee, and therefore am particularly interested in the welfare of the elderly and how the programs this committee oversees affect them. If this committee authorized the new program for women in S. 2303, should elderly women be identified in the legislation as a group which should receive special attention? After all, is it not the case that elderly people use more prescription and over-the-counter drugs than other population groups, and that there is alcoholism among older people too?

Answer: The National Association of State Alcohol and Drug Abuse Directors welcomed the separate authorization of a program to demonstrate the provision of alcohol and drug prevention and treatment services to women as provided in S. 2303. We would also welcome the identification of elderly women in the legislation as a group which should receive special attention as well as we would support a recognition of the needs of pregnant teenagers who are sixteen years or older.

It is true that there is a significant amount of alcoholism among the elderly as there is among the general population. For the elderly, however, diagnosis of this illness is often confused with the signs of senility and therefore it is difficult to determine the extent of this illness within this population. Another unique problem appears for the elderly alcoholic by virtue of the fact that the elderly are often taking significant amounts of prescription or over-the-counter drugs which often can cause life-threatening situations when combined with alcohol. Doctors and the elderly must be adequately educated about this potential life-hazard. What is perhaps one of the greatest problems for elderly persons addicted to alcohol and/or prescription drugs is the acceptance of this addiction by family members and society in general who feel that he or she "does not have many years left so let him/her continue the addiction". As a result of this acceptance and the, at times, lack of detection of the problem in the elderly individual who is often alone and withdrawn from society, health and psychological problems develop and are compounded by the alcoholism or drug abuse resulting in increased hospitalization periods and costs. Addiction causes severe, chronic health problems and interferes with the addicted individual's ability to lead a normal life. Neither age not sex should be a factor in seeking or receiving treatment for this illness.

The CHAIRMAN. Thank you, Mr. Eaton.

Let me ask both of you this question. What programs are currently being administered that recognize the special needs of women in the problems of substance abuse, and do you feel that the program that I have proposed through the reauthorization of the ADAMH block grant will begin the development of some worthwhile programs for women? Dr. Williams?

Dr. WILLIAMS. In answer to the first part of your question, there are programs in existence at this time that do treat women and do treat the needs of women. For example, in Davis County in Utah, where we have treatment, 15 percent of those admitted to our residential programs are women, and a little over a fourth, about 25 percent, are women that are admitted into outpatient treatment programs.

We, in the alcohol and drug field have learned a lot, and we have grown a lot. However, there is still a lot to be learned, and there is still a long way to go. NIMH is currently conducting research. The research they conduct is primarily of an empirical nature. Demonstration projects allow for a step between the empirical data and implementation of new data across the entire system. Demonstration projects allow us to look at the effects of new data on a demonstration area, learn from that experience, and then aply new methodology across the system.

It's difficult to go from empirical research to application without a step in between, and demonstration projects provide for this step. Therefore, we support your proposed demonstration project and will continue to support these kind of efforts.

Mr. EATON. There are several activities going on in all the States. I think most large communities have a few specialized programs, and all the States fund some specialized programs for women. I think the issue is much as Dr. Williams has pointed out. We are learning more at a time when we do not have resources, and we're learning that some of our standard approaches to the treatment of alcoholism and drug abuse are not as appropriate for many women as they are for the dominant male clients.

The CHAIRMAN. I take it you believe we do need different services than what they are presently offering to help women?

Mr. EATON. There is no question that we need different services, and need to look, I think, at the demonstration concept that you have suggested.

The CHAIRMAN. I appreciate the testimony of both of you. I am going to submit written questions to both of you, and I am going to ask that you get your responses back as quickly as possible so that we can complete this hearing record.

I just want to thank both of you for appearing here today.

Dr. WILLIAMS. Thank you.

Mr. EATON. Thank you, Senator.

The CHAIRMAN. Thank you so much.

The final panel of witnesses today is on S. 2311, the Health Maintenance Organization Amendments of 1984. The panel will consist of Mr. Michael Herbert and Mr. Robert Rasmussen. Mr. Herbert is speaker of the house of delegates of the American Medical Care Review Association (AMCRA) and is president of Physician's Health Services of Trumbull, CT. Mr. Herbert is accompanied by Mr. David Main, of Epstein, Becker, Borsidy & Green, legal counsel to AMCRA.

Mr. Rasmussen is president of the Group Health Association of America and is executive director of Prime Health, Inc. of Kansas City, MO, and of course has been introduced by his Senator from Missouri, Senator Eagleton.

I am happy to welcome both of you before the committee. Let's start with you, Mr. Herbert, first.

STATEMENT OF MICHAEL HERBERT, SPEAKER OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL CARE REVIEW ASSOCIATION, AND PRESIDENT, PHYSICIAN'S HEALTH SERVICES, TRUMBULL, CT, ACCOMPANIED BY DAVID C. MAIN, COUNSEL; AND ROBERT F. RASMUSSEN, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND EXECUTIVE DIRECTOR, PRIME HEALTH, INC.

Mr. HERBERT. Thank you, Mr. Chairman. It is indeed a pleasure to speak before you today. My organization, Physician's Health Services, represents 36,000 HMO enrollees and 650 participating physicians in southwestern Connecticut. And as you mentioned, I am also currently speaker of the house of delegates of the American Medical Care Review Association, AMCRA. Founded in 1971, AMCRA, formerly the American Association of Foundations for Medical Care, is the only national organization which represents individual practice association-type health maintenance organizations and other competitive plans.

AMCRA member plans work with industry, labor, insurance, and other organizations in developing and offering competitive health programs that emphasize quality assurance and cost effectiveness through sophisticated utilization review programs.

AMCRA membership currently includes over 140 health organizations representing 34,000 participating physicians and a combined enrollment of well over 2,234,000. Our membership involves 66 federally qualified HMO plans throughout the United States.

Our association is very pleased to have this opportunity to present its views and recommendations on your bill, S. 2311, the HMO Amendments of 1984. The members of our association have followed closely the development of the program of Federal assistance to HMO's over the past 10 years. We believe the Federal Government has contributed generously to the establishment and growth of HMO's and that this Federal support provided the necessary impetus for the movement of HMO's from an experimental model to a position of significance in our health delivery system.

We have now entered a new stage in the evolution of our health delivery system. All of us are aware of the rapid escalation of expenditures for health services and the strains this growth has placed on our public and private resources. We are carefully examining the reasons for health cost inflation and seeking innovative approaches to the moderation of these expenditures.

We believe the HMO industry has and will continue to make an important contribution to the solution of our health cost problem and to the maintenance of accessible and high-quality health services. At the same time, Mr. Chairman, we believe it is appropriate to examine the Federal role in the HMO industry to ensure that it complements new policy directions in other health programs.

At the Federal level, there has been considerable emphasis on reducing the regulatory burden associated with health programs enacted over the past two decades. Increasing reliance is being placed on marketplace incentives as the most efficient and effective means of allocating resources for health care. For the market to operate fairly, competitors must be able to compete on an equitable basis. We see the thrust of your amendments as another step toward the establishment of a level playing field for HMO's and other health delivery systems.

At this time we believe that the remaining objectives of the HMO Act are: One, the maintenance of Federal standards set for HMO's; and two, the assurance of consumer access to HMO's through the dual choice mandate.

The financial assistance which has been available to HMO's through the grant, loan and loan guarantee provisions of title XIII of the Public Health Service Act is being replaced by the upsurge of private investment in the industry. This improving climate for HMO access to the private capital market could not have occurred without the early Federal support. However, we do not believe it is necessary to retain these authorizations in the law except in the case of those organizations with existing commitments for Federal assistance.

We would like now to call your attention to our comments on selected provisions of S. 2311.

Section 2 of the bill removes the requirement for federally qualified HMO's to community rate any supplemental benefits which are offered to enrollees. As the market for health services has become increasingly competitive, attention has focused on the design of benefit plans that are responsive to the needs of the marketplace. Our members believe that if HMO's are to compete effectively in these markets, as I believe they indeed can, some flexibility in the rating process of benefits offered by HMO's is both essential and fair.

Section 2 of the bill recognizes that HMO's are vying for members in the same market as conventional insurers and self-funded employer plans. While HMO's derive considerable cost saving advantage from their effective management of health services and their patterns of practice, it is difficult to remain price competitive in the supplemental benefit area if HMO's must use community rating as the basis of premiums.

In 1981 Congress recognized this problem and included in the HMO amendments that year a modification in the required methodology for establishing HMO premiums. Community rating by class permits the consideration of factors which have been associated with the use of health resources to be reflected in HMO rates. Section 2 continues this type of flexibility for the determination of premiums for supplemental benefits. AMCRA supports the enactment of section 2.

In section 3 of your bill, Mr. Chairman, you have proposed eliminating the requirement for private HMO's to include at least one-third of their members on their governing body. While we support the appointment of HMO members to the governing body of their plan, we believe that it is not necessary for such a requirement to remain in title XIII. The members of our association promote participation in their enrollees on governing boards and in a variety of other roles. At the same time, the repeal of this provision as proposed in section 3 would be consistent with efforts to reduce the regulatory burden of the act, and it has our support.

As we testified before this committee in 1981, we believe that funding for HMO development and initial operations should come from private sources. The purpose of this funding under the original act was to provide a catalyst for the growth of the HMO model. It was never intended to be a perpetual source of financing for mature organizations. The provisions in sections 4, 5, and 6 would repeal the authorizations for appropriations to support new grants, loans, and loan guarantees for operational support and the construction or acquisition of ambulatory care facilities. AMCRA supports enactment of these sections, recognizing that those organizations with existing commitments will be held harmless by such a repeal.

Section 7 of the bill, repealing Health System Agency reviews of proposed Federal assistance to HMO's, is, in our opinion, a necessary conforming amendment, in view of the fact that such assistance will not be available in future years. Furthermore, it represents another opportunity to reduce the regulatory burden on both HMO's and HSA's, and we support enactment of this section.

Mr. Chairman, we also wish to associate ourselves with your view, expressed in your introductory statement accompanying S. 2311, that the requirement for periodic requalification of HMO's is no longer necessary. The departmental review and monitoring program, along with the discretion to withdraw Federal qualification for cause, provides sufficient assurance that statutory standards and practices will be enforced.

Again, we want to express our appreciation for this opportunity to participate in these hearings. AMCRA supports the 3-year reauthorization you have proposed in S. 2311 of the HMO Act, and we believe the modifications you have proposed will reduce the Federal regulatory burden appropriately and ensure that HMO's can compete fully and fairly with one another and with other health delivery systems.

I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Herbert and responses to questions submitted by Senator Hatch follow:]

Statement of

THE AMERICAN MEDICAL CARE AND REVIEW ASSOCIATION

before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

U.S. SENATE

on

S.2311 THE HMO AMENDMENTS OF 1984

February 22, 2984

Mr. Chairman, my name is Michael Herbert, President of the Physicians Health Services, Trumbull, Connecticut, and currently Speaker of the House of Delegates of the American Medical Care and Review Association (AMCRA).

Founded in 1971, AMCRA (formerly the American Association of Foundations for Medical Care) is the only national organization which represents Individual Practice Association-type Health Maintenance Organizations (IPA/HMOs) and other competitive plans. AMCRA member plans work with industry, labor, insurance and other organizations in developing and offering competitive health programs that emphasize quality assurance and cost effectiveness through sophisticated utilization review programs. AMCRA membership currently includes over 140 health organizations representing 34,000 participating physicians and a combined enrollment of well over 2,234,000. Our membership involves 66 federally qualified HMO plans from throughout the United States

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At the federal level, there has been considerable emphasis on reducing the regulatory burden associated with health programs enacted over the past two decades. Increasing reliance is being placed on marketplace incentives as the most efficient and effective means of allocating resources for health care. For the market to operate fairly, competitors must be able to compete on an equitable basis. We see the thrust of your amendments as another step towards the establishment of a level playing field for HMOs and other health delivery systems.

At this time, we believe that the remaining objectives of the HMO Act are:

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2. The assurance of consumer access to HMOs through the dual choice mandate.

The financial assistance which has been available to HMOs through the grant, loan and loan guarantee provisions of Title XIII of the Public Health Service Act is being replaced by the upsurge of private investment in the industry. This improving climate for HMO access to the private capital market could not have occurred without the early federal support. However, we do not believe it is necessary to retain these authorizations in the law except in the case of those organizations with existing commitments for federal assistance. We would like now to call your attention to our comments on selected provisions of S.2311.

Comments on Selected Provisions of S.2311

Section 2. of the bill removes the requirement for federally qualified HMOs to community rate any supplemental benefits which are offered to enrollees.

As the market for health services has become increasingly competitive, attention has focused on the design of benefit plans that are responsive to the needs of the marketplace. Our members believe that if HMOs are to compete effectively in these markets, as I believe they indeed can, some flexibility in the rating process of benefits offered by HMOs is both essential and fair.

Section 2. of the bill recognizes that HMOs are vying for members in the same market as conventional insurers and self-funded employer plans. While HMOs derive considerable cost saving advantage from their effective management of health services and their patterns of practice, it is difficult to remain price competitive in the supplemental benefit area if HMOs must use community rating as the basis of premiums. In 1981, Congress recognized this problem and included in the HMO Amendments that year a modification in the required methodology for establishing HMO premiums. Community rating by class permits the consideration of factors which have been associated with the use of health resources to be reflected in HMO rates. Section 2. continues this type of flexibility for the determination of premiums for supplemental benefits. AMCRA supports the enactment of Section 2.

In Section 3. of your bill, Mr. Chairman, you have proposed eliminating the requirement for private HMOs to include at least one-third of their members on their governing body. While we support the appointment of HMO members to the governing body of their plan, we believe that it is not necessary for such a requirement to remain in Title XIII. The members of our association promote participation of their enrollees on governing boards and in a variety of other roles. At the same time, the repeal of this provision, as proposed in Section 3. would be consistent with efforts to reduce the regulatory burden of the Act, and it has our support.

As we testified before this committee in 1981, we believe that funding for HMO development and initial operations should come from private sources. The purpose of this funding under the original Act was to provide a catalyst for the growth of the HMO model. It was never intended to be a perpetual source of financing for mature organizations. The provisions in Sections 4., 5. and 6. would repeal the authorizations for appropriations to support new grants, loans and loan guarantees for operational support and the construction or acquisition of ambulatory care facilities. AMCRA supports enactment of these sections, recognizing that those organizations with existing commitments will be held harmless by such a repeal.

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Mr. Chairman, we also wish to associate ourselves with your view, expressed in your introductory statement accompanying S.2311, that the requirement for periodic requalification of HMOs is no longer necessary. The departmental review and monitoring program, along with the discretion to withdraw federal qualification for cause, provides sufficient assurance that statutory standards and practices will be enforced.

Again, we want to express our appreciation for this opportunity to participate in these hearings. AMCRA supports the three year reauthorization you have proposed in S.2311 of the HMO Act, and we believe the modifications you have proposed will reduce the federal regulatory burden appropriately and ensure that HMOs can compete fully and fairly with one another and with other health delivery systems.

I will be happy to respond to any questions you or other members of the committee may have. Thank you.

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John M. Kenney, M.D.
Santa Rosa, California

Mary Lundberg
Buffalo, New York

Henry Minear, M.D.
Westfield, New Jersey

Anthony Sitten
Phoenix, Arizona

Donald Raines, M.D.
Rochester, New York

Kerry Tarvin
Cincinnati, Ohio

SPEAKER OF THE HOUSE
Michael Herbert
Trumbull, Connecticut

VICE SPEAKER OF THE HOUSE
James G. Stampfer
San Diego, California

RECEIVED APR 10 1984

April 3, 1984

The Honorable Orrin G. Hatch
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Dear Senator Hatch:

This is in response to your letter of February 28, 1984, in which you asked me for some additional comments on the following questions you raised in connection with the proposed Health Maintenance Organization Amendments of 1984.

Question No. 1: Could you explain how an IPA differs from the more traditional group or staff HMO?

> A health maintenance organization (HMO) is a health care plan that delivers comprehensive, coordinated medical services to voluntarily enrolled members on a prepaid basis. A group/staff HMO delivers services at one or more locations through a group of physicians that contracts with the HMO to provide care through its own physicians who are employees of the HMO. In an IPA, or individual practice association type of HMO, contractual arrangements are made with doctors in the community who practice out of their own offices and see HMO members there. The IPA model contracts with local hospitals, rather than own their own as do some group models. In summary, the IPA builds upon existing facilities and services.

Question No. 2: I understand that one proposal being considered in some quarters is to eliminate the Section 1312(B)(1) reconsideration and hearing requirement for the withdrawal of Federal qualifications for an HMO. Do you have a position on this issue?

> In my testimony before your Committee on S.2311, I expressed our agreement with your view that the requirement for periodic requalification of HMOs is no longer necessary. Departmental review and monitoring programs, along with the discretion to withdraw Federal qualification for cause, provides assurances that statutory standards will be adhered to. But, the essence of the Federal statute is the

certification of Federal qualification. We believe that the reconsideration and hearing features contained in Section 1312 provide qualified HMOs with an important mechanism to present their side in any disputes over compliance with the Government's qualification requirements.

Despite easing of a number of burdensome requirements applicable to HMOs, the Federal HMO Act as administered by the Department of Health and Human Services is still a highly regulatory system. Many of its provisions are general (such as the requirement that all HMOs "have a fiscally sound operation" and that they have management "satisfactory to the Secretary") and open to subjective and even arbitrary enforcement. As a matter of due process, it is important that organizations under such a system have a fair hearing available to them before federal qualification can be revoked. This also is consistent with state licensure protections in most states, and with a policy of avoiding over-regulation of HMOs. To my knowledge, the hearing requirement has not been onerous or costly, or resulted in the Department being unable to enforce the Act. To the contrary, its mere existence has probably made the Department more attentive to due process in the day-to-day administration of the law. Thus, the current hearing requirement, originally sponsored by Senator Hatch, is a wise one and should be retained.

Question No. 3: Other than what we are doing, what steps do you believe we could take to improve the competitive climate of HMOs?

First of all, Mr. Chairman, we would like to express again our support for many of the steps you and your Committee are taking to improve the competitive climate for HMO development in the United States by working to eliminate some of the regulatory burdens imposed by certain aspects of the Federal HMO law. As I noted in our testimony, we believe that there must be a reasonable flexibility in the area of rating benefits offered by HMOs if competition in the marketplace is to be both fair and reasonable for all parties. Regrettably, not all States - some of which also have extensive regulation governing HMOs - have seen fit to improve the competitive environment for alternative delivery systems by removing such barriers as well. It is our hope that both Federal and State legislators will continue to consider with an

> open mind our requests to reduce all regulatory burdens that prevent HMOs from competing fully and fairly with one another and with other health care delivery systems.
>
> Heavy government regulation is always a barrier to private investment. We support whatever you can do to minimize the regulatory burdens on HMOs and to maximize government cooperation with investors' timetables on necessary approvals for HMOs seeking private financing. Also, lessening regulatory requirements will improve HMOs' ability to be flexible, offer competitive products and succeed in meeting marketplace demands vis-a-vis their less regulated competitors.

I appreciate the opportunity to provide these additional views and to respond to your questions.

Sincerely,

Michael Herbert
President
Physicians Health Services
Trumbull, Connecticut
Speaker of the House
American Medical Care and Review Association

MH:jlw

The **Chairman**. Thank you, Mr. Herbert.

We note that Mr. David Main is with you.

We welcome him back to the committee.

For those in the room who do not know who David is, he was minority counsel for the Health Subcommittee when Senator Schweiker was here and was the ranking minority member. And of course, Senator Schweiker was my predecessor on the Republican side of the committee.

We are very happy to welcome you once again.

Mr. **Main**. Thank you, Mr. Chairman. It's a pleasure to be here.

The **Chairman**. Thank you.

We will turn to you, Mr. Rasmussen, now, and you will be our final witness.

Mr. **Rasmussen**. Thank you, Senator.

I would like my complete statement to appear in the record, and I will present a summary.

The **Chairman**. We will, without objection, place your longer version of your statement into the record, and we appreciate your summarizing.

Mr. **Rasmussen**. Thank you, Mr. Chairman.

I also would like to acknowledge Senator Eagleton's kind words about Prime Health in Kansas City. He has been a great supporter of ours, and we appreciate his remarks.

As you have noted, I am Bob Rasmussen, president of Group Health Association of America, GHAA, and executive director of Prime Health.

GHAA represents over 120 prepaid group practice plans, a majority of the group and staff model health maintenance organizations in the country. GHAA's member plans serve approximately 10 million enrollees, 80 percent of the total national HMO enrollment. Prime Health is a staff model HMO located in Kansas City, MO, a product of the development under this act, and it now has over 50,000 members after 7 years of operation.

GHAA is pleased to have an opportunity to comment on Senate bill 2311, the Health Maintenance Organization Amendments of 1984, recently introduced by you.

We would like to begin by thanking you, Mr. Chairman, for the very positive introductory statements which accompanied the bill. We are grateful for your serious interest in HMO's and for your continued support.

While we have few problems with the specific provisions of your bill and appreciate your desire to improve the HMO Act in modest ways, we would nevertheless urge you not to undertake the amendment of the act this year beyond any technical amendments to the loan fund authority.

The HMO Act, in its present form, is causing no significant operational problems for GHAA member plans, and under its provisions HMO's are currently receiving their strongest support to date from the employer community. Given these circumstances and the lengthy and often difficult process by which the act reached its present form, we are strongly urging that the act simply be permitted to work and that no changes be considered this year.

Over 10 years after enactment of the original HMO Act, HMO's have become an accepted part of the health care marketplace and their popularity with employers, unions, and consumers alike is impressive. In the past 1 or 2 years in particular, HMO's have grown in their attractiveness because of their ability to maintain comprehensive benefits while achieving significantly lower premium increases than their competitors.

A study by the Massachusetts Hospital Association for the 15-month period ending in March 1983, showed that health insurance premiums in the State increased 20 to 40 percent annually, while HMO premiums increased only 15 to 18 percent. Indications from GHAA members across the country are that this experience is not an isolated one. Further, in a fairly recent development, HMO premiums are often lower in absolute terms than those of other carriers despite the more comprehensive HMO benefits.

As a result of our success in controlling costs while maintaining comprehensive, high-quality care, employers today are more enthusiastic in their support of the HMO option than ever before. The employer community has been awakening to the important impact it can have as a purchaser of health care services. While some employers are moving toward benefit packages with higher copayments and deductibles in an effort to hold down premium increases among traditional carriers, comprehensive HMO coverages are growing in their attractiveness.

The role of the HMO Act as a backdrop for the impressive marketplace performance of HMO's has been an important one. While HMO's could not have succeeded without providing high-quality care at competitive rates, the HMO Act has been critical to permitting HMO's to gain the entry into the health care marketplace which has given them the opportunity to prove themselves. The significance of the dual choice provision in this regard cannot be underestimated. The provision created the atmosphere in which employers began to voluntarily offer federally qualified HMO's.

Of nearly equal importance have been the standards for Federal qualification, which assure that important basic criteria are met in areas such as comprehensiveness of benefits, fiscal soundness, and quality assurance.

Currently, the scope of the HMO Act is well known to interested employers, consumers, and HMO's, and the climate for HMO growth and development of which it is an important part is highly favorable. Almost all States have enacted their own HMO regulatory mechanisms, many of which follow the pattern of the Federal act. These enactments and the 1981 HMO Act provisions sponsored by Senator Hatch have all but eliminated problems involving HMO solvency, which arose several years ago. From our perspective, there are no changes in the act which justify opening it for substantive debate and amendment at this time.

To comment briefly on the specifics of S. 2311, the provision which deletes the requirement that supplemental health benefits offered on a prepaid basis must be community rated is unnecessary at this point. While additional flexibility might well have merit, we have heard no complaints from our members about the present requirement and see no need to alter it this year.

With respect to the proposed change in the board composition requirement, GHAA has long been on record in support of the present provision mandating that one-third of the board must be

HMO members. Although HMO's seek meaningful consumer input through a variety of means, the significance of board representation is widely recognized, and the requirement is not generally viewed as burdensome.

The proposed amendments to repeal grant and loan authority and related provisions are not necessary, since funding cannot be expected to be provided again. And the provisions altering compliance and OHMO reporting requirements, while they may be useful, are similarly not of sufficient importance to require action this year.

We support provisions which ensure the availability of loan funds for the costs of initial operation for those HMO's which currently hold loan commitments, but these are essentially technical in nature.

Finally, while we considered the HMO management training program to be a significant contributor to the pool of skilled HMO managers and although technical assistance has been one of the most successful programs in which GHAA has participated, the growing number of national HMO firms and national cooperative management and development efforts is resulting in a sharing of expertise which has made these governmental programs less than essential.

In conclusion, in 1970 there were only 26 HMO's in the country, serving about 3 million members, while currently there are 280 HMO's nationally, serving approximately 12.5 million members. The climate for HMO growth has never been more positive, and it is now marked by unprecedented employer and consumer acceptance. While future changes in the health care marketplace may call for alterations in the HMO Act, the act is now working well and playing a positive role in a very promising era for HMO development. Although we are grateful for your desire to improve the act, we strongly urge you to defer any amendments beyond those needed for the operation of the loan fund, in light of the act's current practical workability.

Thank you, sir.

The CHAIRMAN. Thank you. Mr. Rasmussen, you indicate that you feel it unnecessary for the community rating requirements for supplemental health services to be revised at this time. Let me put it this way. If Congress were to take such a step, would your membership welcome it?

Mr. RASMUSSEN. I do not think it would make any difference, to be honest with you. It would not change the way we presently operate or rate those particular benefits. For instance, we voluntarily offer to all of our membership a drug benefit, which is not required under the act, and we would continue to do that and rate it the same way we have been doing it.

The CHAIRMAN. You would not mind then having it revised?

Mr. RASMUSSEN. I think one of the more fundamental aspects of this program is community rating. I think community rating is an essential part of the genetic code of HMO's. And I think that erosion in that area is difficult to support.

The CHAIRMAN. Where do you come down, Mr. Herbert, on that?

Mr. HERBERT. Well, we are obviously in support of experience rating for the supplemental benefits. I am not sure how our association feels about whether community rating per se ought to be maintained within the act.

I can tell you personally that our organization would consider removal of the community safety requirement for supplemental benefits a positive step in order to be better able to compete with the self-administered plans and self-funded plans which are causing us some significant competition in the Connecticut area.

The CHAIRMAN. I am going to submit further questions for both of you. I would appreciate it if you would answer them as quickly as possible.

[The prepared statement of Mr. Rasmussen and responses to questions from Senators Hatch and Grassley were subsequently submitted for the record:]

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STATMENT OF

ROBERT F. RASMUSSEN

PRESIDENT

GROUP HEALTH ASSOCIATION OF AMERICA, INC.

AND

EXECUTIVE DIRECTOR

PRIME HEALTH

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ON

S. 2311, HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1984

WASHINGTON, D.C.

FEBRUARY 22, 1984

Mr. Chairman and members of the Committee, I am Robert Rasmussen, President of Group Health Association of America (GHAA) and Executive Director of Prime Health. GHAA represents over 120 prepaid group practice plans, a majority of the group and staff model health maintenance organizations (HMOs) in the country. GHAA's member plans serve approximately 10 million enrollees, 80% of the total national HMO enrollment. Prime Health is a staff model HMO located in Kansas City, Missouri. The plan now has over 47,000 members after 7 years of operation.

GHAA is pleased to have an opportunity to comment on S. 2311, the Health Maintenance Organization Amendments of 1984, recently introduced by Senator Hatch. We would like to begin by thanking you, Mr. Chairman, for the very positive introductory statement which accompanied the bill. We are grateful for your serious interest in HMOs and for your continued support. While we have few problems with the specific provisions of your bill and appreciate your desire to improve the HMO Act in modest ways, we would nevertheless urge you not to undertake amendment of the Act this year beyond any technical amendments to the loan fund authority.

The HMO Act in its present form is causing no significant operational problems for GHAA member plans, and under its provisions HMOs are currently receiving their strongest support to date from the employer community. Given these circumstances and the lengthy and often difficult process by which the Act reached it present form, we are strongly urging that the Act simply be permitted to work and that no changes be considered this year.

Over ten years after enactment of the original HMO Act, HMOs have become an accepted part of the health care marketplace and their popularity with employers, unions and consumers alike is impressive. As an example, the contract negotiated last fall between AT&T and the Communications Workers of America established a joint committee on cost containment one of whose purposes is to seek ways and means of encouraging HMO membership.

In the past year or two in particular HMOs have grown in their attractiveness because of their ability to maintain comprehensive benefits, while achieving significantly lower premium increases than their competitors. A study by the Massachusetts Hospital Association for the fifteen month period ending in March, 1983, showed that health insurance premiums in the state increased 20 to 40 percent annually, while HMO premiums increased only 15 to 18 percent. Indications from GHAA members across the country are that this experience is not an isolated one. Further, in a fairly recent development, HMO premiums are often lower in absolute terms than those of other carriers despite the more comprehensive HMO benefits.

Spurred in part by this success in holding down premium increases, HMO enrollments have been rising at a very healthy rate of 15 percent a year. Consumer willingness to investigate HMO membership has been heightened by attractive premiums, as well as comprehensive benefits with limited out-of-pocket costs. However, the role played by employers in actively promoting employee awareness of HMO offerings has been critical to the recent strong HMO growth. A 1980 Louis Harris survey showed that the majority of HMO members first learned of their HMOs through their employers and an overwhelming majority joined through their own employers or the employers of other family members.

As a result of our success in controlling costs while maintaining comprehensive high quality care, employers today are more enthusiastic in their support of their HMO options than ever before. The employer community has been awakening to the important impact it can have as a purchaser of of health care services. While some employers are moving towards benefit packages with higher copayments and deductibles in an effort to hold down premium increases among traditional carriers, comprehensive HMO coverages are growing in their attractiveness. Xerox Corporation recently experienced an 84 percent increase in its HMO enrollment nationwide spread among 76 HMOs. IBM now offers over 160 HMOs and is evaluating the cost effectiveness to the company of its HMO offerings.

The Ford Motor Company has already examined the value of its HMO offerings, and in 1983 estimated that with HMO premiums averaging 16 percent below other carriers, a $7 million savings would result. The company offers 27 HMOs and by the next open enrollment period this spring, expects to be offering 32 HMOs. In March, 1983, Philip Caldwell, Chairman of the Board at Ford, mailed an unprecedented letter to every Ford employee encouraging examination of the HMO options available. Caldwell pointed out that HMO enrollment among Ford workers has increased 60 percent during the last five years and stated "the HMO approach provides an efficient, top-notch health care plan, limits out-of-pocket expenses for participants and lowers the Company's health care costs." With this sort of support, Ford experienced a healthy increase in HMO enrollment among unionized workers which brought penetration to 9% of the eligible workforce. In a fall open enrollment period for salaried employees, enrollment increased by 9,000 members to 20% of those eligible to join.

Chrysler has gone even farther in encouraging its employees to consider joining the HMO it offers in Detroit, Health Alliance Plan of Michigan (HAP). Recognizing that satisfied members are an HMO's best marketers, during the

1983 open enrollment period the company offered each worker who was then an HAP member a savings bond of up to $250 for each enrollment by a fellow worker who joined the HMO on the member's recommendation. A Chrysler brochure stated, "Chrysler can offer this special enrollment incentive because of HAP's favorable premium rates."

The role of the HMO Act as a backdrop for the impressive marketplace performance of HMOs has been an important one. While HMOs could not have succeeded without providing high quality care at competitive rates, the HMO Act has been critical to permitting HMOs to gain the entry into health care markets which has given them the opportunity to prove themselves. The significance of the dual choice provision in this regard cannot be underestimated. The provision created the atmosphere in which employers began to voluntarily offer federally qualified HMOs. Today, growing numbers of large employers offer multiple HMOs, and employer receptivity to HMO offerings goes far beyond the basic requirements of the statute.

Of nearly equal importance have been the standards for federal qualification. While less than perfect, as any regulatory scheme must be, they have achieved the purpose of making federal qualification a "Good Housekeeping seal of approval" which assures employers and consumers that important basic criteria are met in areas such as comprehensiveness of benefits, fiscal soundness and quality assurance. Despite the demise of programs of federal financial assistance for HMOs, plans continue to apply for federal qualification as a sign of responsible management and a commitment to quality care and in order to receive the benefits of dual choice.

Currently, the scope of the HMO Act is well-known to interested employers, consumers and HMOs, and the climate for HMO growth and development of which it is an important part is highly favorable. Almost all states have enacted their own HMO regulatory mechanisms, many of which follow the pattern of the federal Act. These enactments and the 1981 HMO Act provision sponsored by Senator Hatch have all but eliminated problems involving HMO solvency which arose several years ago. From our perspective, there are no changes in the Act which justify opening it for substantive debate and amendment at this time.

To comment briefly on the specifics of S. 2311, the provision which deletes the requirement that supplemental health services offered on a prepaid basis must be community rated is unnecessary at this point. While additional flexibility might well have merit, we have heard no complaints from our members about the present requirement and see no need to alter it this year.

With respect to the proposed change in the board composition requirement, GHAA has long been on record in support of the present provision mandating that one-third of the board must be HMO members. Although HMOs seek meaningful consumer input through a variety of means, the significance of board representation is widely recognized, and the requirement is not generally viewed as burdensome.

The proposed amendments to repeal grant and loan authorities and related provisions are not necessary since funding cannot be expected to be provided again, and the provisions altering compliance and OHMO reporting requirements, while they may be useful, are similarly not of sufficient importance to require action this year.

We support provisions which insure the availability of loan funds for the costs of initial operation for those HMOs which currently hold loan commitments, but these are essentially technical in nature.

Finally, while we considered the HMO management training program to be a significant contributor to the pool of skilled HMO managers and although the technical assistance has been one of the most successful programs in which GHAA has participated, the growing number of national HMO firms and national cooperative management and development efforts is resulting in a sharing of expertise which has made these government programs less than essential.

In conclusion, in 1970 there were only 26 HMOs in the country serving about 3 million members, while currently there are 230 HMOs nationally serving approximately 12.5 million members. The climate for HMO growth has never been more positive, and it is now marked by unprecedented employer and consumer acceptance. While future changes in the health care marketplace may call for alterations in the HMO Act, the Act is now working well and playing a positive role in a very promising era for HMO development. Although we are grateful for your desire to improve the Act, we strongly urge you to defer any amendments beyond those needed for the operation of the loan fund in light of the Act's current practical workability.

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group Health association of america, inc.
624 Ninth Street, N.W., Suite 700 • Washington, D.C. 20001 • (202) 737-4311

April 12, 1984

The Honorable Orrin Hatch
Chairman
Senate Labor and Human Resources Committee
SD-428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Hatch:

Following the hearing on February 22, 1984, at which I presented testimony on S. 2311, the Health Maintenance Organization Amendments, on behalf of Group Health Association of America, you forwarded an additional question and requested my answer for the hearing record. My response is enclosed.

I appreciated the opportunity to testify and hope that you or your staff will contact me if further information is needed.

Sincerely,

Robert F. Rasmussen ck

Robert F. Rasmussen
President

Enclosure

1983-84
Executive Committee

Chairman of the Board
Robert L. Biblo
Health Insurance Plan of Greater New York

President
Robert F. Rasmussen
Prime Health

Vice President
Thomas O. Pyle
Harvard Community Health Plan

Treasurer
Roger Birnbaum
Rutgers Community Health Plan

Secretary
Carl E. Berner, Jr
Kaiser Foundation Health Plan

Members

Harris A. Berman, M.D.
Matthew Thornton Health Plan

Robert J. Erickson
Kaiser Foundation Health Plan, Inc.

Robert Gumbiner, M.D.
F.H.P. Inc.

Samuel Havens
Prudential Insurance Company

Joseph L. Marcarelli, M.D.
CIGNA Healthplan, Inc.

Warren Paley
Capital Area Community Health Plan, Inc.

Robert G. Rosenberg, M.D.
Group Health Association, Inc.

Leonard D. Schaeffer
Group Health Plan, Inc.

Bert Seidman
AFL-CIO

James Walworth
Health Alliance Plan of Michigan

Gail Warden
Group Health Cooperative of Puget Sound

Executive Director
James F. Doherty

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

Response for the Record
Hearing of February 22, 1984

QUESTION:

"What further steps do you feel that we at the federal level can take to improve the competitive climate of HMO's?"

RESPONSE:

The federal HMO initiative developed by the Congress in 1973 contained three major elements: first, override of restrictive legislation in 38 states; second, a requirement that employers offer the HMO alternative; and third, a provision of modest seed money for the development of HMOs. These initiatives have been eminently successful. Some 48 states now have their own enabling or regulatory legislation. The dual choice mandate has received overwhelming support from employers generating a threefold increase in enrollment and at least a 15 percent growth rate which is expected to continue or increase. Phase out of the federal funding has been met with a more than commensurate infusion of capital from the private sector.

HMO growth will continue at an accelerated rate limited only by the availability of the necessary human and physical resources to meet the demand. Federal funding for increased development and expansion is no longer practical or desirable. Any existing statutory impediments are not major obstacles. We would urge that the appropriate committees of the Congress carefully scrutinize changes in a volatile health care marketplace and proposals for legislative enactments which regulate the health care field to assure that the current successful growth of HMOs not be slowed.

RESPONSE TO
QUESTIONS FROM
SENATOR CHARLES E. GRASSLEY

1) Are HMO's primarily an urban phenomenon? Nationally, how many are in urban areas and how many are in rural areas or small towns?

If they are primarily an urban phenomenon, why is this so? Do rural HMO's face special problems which make them more difficult to operate than HMO's in urban areas?

If so, do we need any special incentives or assistance to rural HMO's?

It is true that HMOs have been established primarily in urban areas, although in GHAA we have several members who have developed HMOs in rural communities, for example in New York, Colorado and Minnesota. Among the 120 GHAA member plans, at least 9 serve rural areas or small towns. We do not have an urban/rural breakdown of the approximately 290 HMOs nationwide.

The smaller population base in rural areas makes it difficult to develop group and staff model HMOs, but it is also difficult to attract and retain individual medical practitioners in these areas. We are sympathetic to the health care needs of rural communities and small towns, and we and our members who serve such areas would be happy to work with you to explore ways to improve the availability of health services through HMO development outside of urban areas.

2) The assumption underlying deletion of the requirement that supplemental health services offered on a prepaid basis must be community rated is that HMO's would then be able to set fees on an experience basis and thus become more competitive with conventional insurance. One consequence could be that HMO's could offer additional services.

I understand that your membership is not demanding this, but do you feel that if we took this step with S. 2303 we would not be improving the situation for HMO's?

As I stated in response to Senator Hatch's question, I do not believe that deletion of the requirement that supplemental services offered on a prepaid basis must be community rated, as proposed in S. 2311, would alter the benefit offerings of HMOs or the way in which they are rated, and I do believe that community rating is the rating system most compatible with HMO operations. Therefore, my view is that deletion of the requirement would not be an improvement.

The **Chairman**. Let me turn to Senator Pell.

Senator **Pell**. I have no questions. Thank you.

The **Chairman**. Well, thank you so much for being here. We appreciate all the witnesses.

With that, we will recess this committee until further notice.

[Whereupon, at 11:50 a.m., the committee recessed, to reconvene at the call of the Chair.]

BLOCK GRANTS AND OTHER HEALTH SERVICE PROGRAMS, 1984

WEDNESDAY, MARCH 7, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:40 a.m., in room SD-430, Dirksen Senate Office Building, Senator Orrin Hatch (chairman of the committee) presiding.

Present: Senators Hatch, Kennedy, Pell, Grassley, and Randolph.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. It is my pleasure to chair this second day of hearings to consider five major reauthorizations of the Public Health Service Act.

During our first hearing, on February 22, Assistant Secretary for Health of the Department of Health and Human Services, Dr. Edward Brandt, addressed all five bills and the committee received additional testimony on two of the bills, the Alcohol, Drug Abuse, and Mental Health Block Grant, S. 2303, and Health Maintenance Organizations, S. 2311.

At the February 22 hearing, Dr. Brandt reported that the block grant mechanism is working smoothly, with States using these Federal funds to solve their own unique health care problems. The administration's encouraging words reveal a readiness to work with us to reauthorize these programs, and to make them work even better.

We also heard from the National Council of Community Mental Health Centers and the National Association of State Alcohol and Drug Abuse Directors, both of whom support my effort to secure a 3-year authorization of the Alcohol, Drug Abuse, and Mental Health Block Grant Program, as proposed in my legislation, S. 2303.

The American Medical Care Review Association testified in support of my bill, S. 2311, the 3-year reauthorization of the Health Maintenance Organization Act, concluding that this legislation will reduce the Federal regulatory burden while ensuring that HMO's compete fully and fairly with one another as health delivery alternatives.

During today's hearing we will hear testimony on the three other bills: The Preventive Health Services Block Grant, S. 2301; the Primary Care Block Grant, S. 2308; and the National Health Service Corps Amendments, S. 2281. Our distinguished witnesses, representing the General Accounting Office, the Association of State and Territorial Health Officials, urban and rural coalitions, and the Michigan Department of Health, represent diversity and formidable expertise.

The block grant program for health protection and disease prevention, a product of our 1981 committee deliberations, will soon be cited in a forthcoming GAO report for its overall effectiveness as a balanced and workable block grant approach. The Health Services, Preventive Health Services, and Home and Community Based Services Act of 1984, S. 2301, reauthorizes the preventive health and health services block grant. The existing home health care training program and the tuberculosis, venereal disease, and immunization categorical grant programs will also be reauthorized. In addition, the bill authorizes a new home and community based health services block grant, as well as a 3-year demonstration project related to improving emergency medical services for children.

The home health care block grant included in this reauthorization is an updated version of my earlier bill, S. 1539, which this committee favorably reported last year. I believe today, as I did then, that improved home health care deserves more than polite lip service. Many senior citizens who are infirm and in need or disabled can receive care and attention in their own homes or apartments where they so often desperately need to stay.

Home health care is humane. It is cost effective in the long run. It is an idea whose time has come.

A second program, the primary care block grant, was established as a voluntary program. Unfortunately, this block grant is off to a slow start. We need to find ways to get more States involved. The Department of Health and Human Services has taken the first step by developing formal and informal relationships that encourage States to assume certain responsibilities in the community health center and primary care programs. To date, 40 States have already participated in this approach through memorandums of agreement with DHHS.

I am encouraged by the Department's efforts, but I am convinced of the need to amend the primary care block grant statute to further encourage State participation. Several States have expressed interest in participating, and are likely to do so with the changes I am proposing in S. 2308.

Finally, we will hear testimony on the National Health Service Corps Program. The growth of the Corps has justifiably leveled off since 1981. The number of Corps members is now in harmony with evidence that a surplus of physicians is having a significant effect on the geographic distribution of health professionals. I know that there are parts of our country that will not be able to attract sufficient health care practitioners without the National Health Service Corps, even in the face of a doctor glut. This is why I support the Corps as a modest but effective long-term means of voluntarily moving health care professionals into areas in greatest need.

The National Health Service Corps Amendments of 1984, S. 2281, reauthorizes the National Health Service Corps Field Program and provides a small scholarship program for fiscal years 1985, 1986, and 1987. The bill also directs the Secretary to transmit to the Congress a long-range staffing plan based on a total Corps size of 2,100 people or such lesser numbers consistent with the needs in health manpower shortage areas.

At this point we will insert in the record the opening statement of Senator Kennedy and the prepared statements of Senators Hawkins and Grassley.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. I am pleased to be here this morning to discuss health promotion and disease prevention, the Community Health Centers Programs, and the National Health Service Corps. These are all causes close to my heart. In 1975, I introduced legislation that formulated national goals for health promotion and prevention and established or improved grant programs in high priority areas to reduce preventable illness, disability, and death. In 1978, I introduced legislation that laid the groundwork for the "Healthy People Report," authorized community-based comprehensive prevention programs, and extended and improved prevention project grant programs. I was the original sponsor of the Community Health Centers Program and have been deeply involved in the National Health Service Corps since its conception.

Since the days when I first attempted to place health promotion and disease prevention at the center of our national health agenda, there has been a growing recognition that a comprehensive, aggressive prevention strategy can be our most effective weapon in the struggle to secure health and well-being for the American people. As Assistant Secretary Brandt recently stated, "The time has come for us to turn our attention as a nation to the preservation of good health, the promotion and enhancement of healthful lifestyles, and the prevention of disease and disability."

The knowledge base for rapid improvements in the health of the American people through an effective prevention strategy is now in place. The 1979 Surgeon General's report, "Healthy People," identified major health problems for each of five broad age groups and 15 priority areas for further action. The Surgeon General's 1980 followup report, "Promoting Health/Preventing Disease," established 226 measurable prevention objectives for these 15 priority areas. The Center for Disease Control has developed model prevention standards for community health services. The prevention-oriented activities of the Public Health Service have been inventoried and given renewed emphasis.

Implementation of the goals outlined in this series of reports will result in dramatic improvements in the health and well-being of the American people. By the end of this decade, we can anticipate: A 35 percent reduction in infant mortality; a 20 percent drop in deaths among children; a 20 percent decline in adolescent deaths; a 25 percent lower death rate among adults; and 20 percent less disability for older Americans.

But these lower death and disability rates and all they imply for healthier, happier, more active, and productive lives will not occur simply because we have a roadmap showing how to get from here to there. We need an aggressive national policy if we are to achieve these goals.

The major missing ingredient in our national prevention strategy has been the lack of an effective Federal-State partnership to assure comprehensive prevention planning and service delivery at the State and community level where people can be reached most effectively.

The preventive health block grant should be the key vehicle for development of an effective Federal-State partnership. Instead, this block grant is an example of the Reagan so-called New Federalism at its worst. Essentially a thinly disguised attempt to eliminate the Federal responsibility for a grab-bag of categorical programs, this block was established without standards, priorities, accountability, measurement, or a clear relationship to either national or local objectives.

I will shortly be introducing legislation to transform this block grant into an effective vehicle for helping to achieve the vital goals laid down in the Surgeon General's report. This legislation will assist States in planning comprehensive preventive service delivery, will assure careful measurement of our progress in meeting prevention goals, and will provide funding levels sufficient to make a real impact on our prevention needs.

Community health centers are at the center of another health area of vital concern to the American people, access to health care of the poor and underserved. This program has not only provided services to people with no other satisfactory access to health care, it has done so in a truly exemplary manner.

Last year, community health centers provided high quality, comprehensive care to over 4.5 million people. They have a proven record of increasing the use of preventive services, of reducing illness and hospitalization rates among the deprived populations they serve, and of holding their costs to levels considerably below those of other health care providers.

To cite just a few examples, CHC's between 1974 and 1983 increased their volume of services by more than 300 percent while grant funding increased by only 43 percent. At the same time, costs per encounter decreased 60 percent in real terms. Independent studies have found hospitalization rates that are 50 percent lower for individuals using CHC's then for comparable persons without access to CHC services. These lower hospitalization rates are estimated to have saved the medicaid program alone over one-half billion dollars last year; more important than the dollar savings are the needless suffering and illness avoided.

All in all, community health centers have a tremendous record of accomplishment in providing health care services to the poor.

And these services are needed more today than ever before. The Reagan administration's failed economic policies have plunged an additional 8 million people into poverty; reckless changes in welfare policies have denied medicaid eligibility to hundreds of thousands of mothers and children. Cuts in medicare benefits have made access to care of the elderly more difficult.

Despite this need, the Reagan administration budget would fund CHC's at a level that, after correcting for inflation, is 50 percent below the 1980 level. I believe real growth is as important in the health budget as it is in the defense budget. The CHC program deserves and needs increased support, and that the direct funding relationship betwen the Federal Government and community-based CHC's that has served us so well in the past should be continued. I will shortly be introducing legislation to achieve both these objectives.

Regarding the National Health Service Corps, this program, too, has a proven record of accomplishment in providing health care resources to underserved rural and urban locations all over the country. Changing conditions such as the enhanced supply of physician manpower dictate modifications in this program. But we must be careful to assure that any changes we make allow the corps to continue its essential mission of providing access to health care in areas that would otherwise lack essential services.

I look forward to hearing the comments of our witnesses on how we can improve these programs.

[The statements referred to follow:]

March 7, 1984

STATEMENT OF SENATOR HAWKINS
ON
S. 2301

Mr. Chairman, I am sorry that I will not be able to attend today's hearings on proposals to reauthorize health programs under our Committee's jurisdiction, but I want to take this opportunity to express my strong support of the provisions contained in S.2301, the Health Services, Preventive Health Services and Home and Community Based Services Act of 1984.

I appreciate your support for continuing the authorization of the Tuberculosis control program as a categorical grant. Like venereal diseases and childhood diseases, this is a high priority preventive health program which is critical to our nation's health. Tuberculosis, although easily diagnosed and treatable, remains a major health concern and risk throughout our nation, particularly in urban areas experiencing a major influx of refugees. Miami's tuberculosis case rate is over six times the national rate. However, the categorical tuberculosis grant funds allocated to the Dade County Public Health Department is already having a significant impact. The use of federally financed Creole and Spanish speaking outreach workers and directly observed therapy has increased the percent of patients completing their outpatient therapy from 35% to 85%.

Although the funding levels for tuberculosis control are lower in S.2301, that that contained in my T.B. reauthorization legislation, S.1176, I feel that if the House and Senate Appropriations Committees agree to fund these programs at their fully authorized levels, we can reach our goal of controlling and hopefully eradicating these infectious diseases.

I am also supportive of two new provisions contained in S.2301, the grants for demonstration projects for the expansion and improvement of emergency medical service systems, including services for the treatment of critically ill children, and the new provision authorizing an additional $150 million in federal block grant funding for the coordination and development of community based and home health services for the elderly and disabled. The need for community and home health services has been well documented in hearings in the Senate Labor & Human Resources Committee and the Subcommittee on Aging. The hearing record clearly demonstrates the need to expand our community based support systems to enable our elderly and disabled citizens to continue their full and productive lives. Too many elderly and disabled individuals are unnecessarily institutionalized when they don't really require that level of health care. I believe that federal funds expended for community based home services such as homemaker services, adult daycare, home health care, dietary services, physical occupational and speech therapy and other types of services that enables an elderly or disabled individual at risk of being institutionalized to remain in their own homes will reduce the overall costs to the government as it enhances the quality of that individuals life.

STATEMENT OF CHARLES E. GRASSLEY
BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES
March 7, 1984

MR. CHAIRMAN, I WANT TO THANK YOU AGAIN FOR ORGANIZING THIS SERIES OF EARLY HEARINGS SO THAT WE WILL BE ABLE TO REPORT THESE PROGRAMS OUT RELATIVELY QUICKLY.

THE THREE PROGRAMS ABOUT WHICH WE WILL HEAR TODAY ARE IMPORTANT ONES. THIS IS PARTICULARLY THE CASE FOR THE PREVENTION PROGRAMS WE WILL REAUTHORIZE UNDER S. 2301. I THINK IT IS SAFE TO SAY THAT THE PREVENTIVE APPROACH TO HEALTH CARE EVENTUALLY PAYS SUBSTANTIAL DIVIDENDS IN THE FORM OF BETTER HEALTH AND REDUCED HEALTH CARE COSTS. IT IS DIFFICULT TO THINK OF HEALTH PROGRAMS WHICH HAVE BEEN SOUNDER INVESTMENTS THAN THE PROGRAMS IN CHILDHOOD IMMUNIZATION, TUBERCULOSIS AND VENEREAL DISEASE. THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT SERVICES HAVE ALL PRODUCED BENEFITS IN EXCESS OF WHAT THESE SERVICES THEMSELVES COST.

THE NATIONAL HEALTH SERVICES CORPS IN ANOTHER PROGRAM WHICH HAS HELPED TO GET NEEDED MEDICAL CARE TO MEDICALLY UNDERSERVED AREAS OR POPULATIONS, MANY OF WHICH ARE IN RURAL PARTS OF THE COUNTRY. MY OWN STATE OF IOWA HAS SOME 27 CORPSMAN, EITHER DENTISTS, GENERAL MEDICAL PRACTITIONERS, OR OSTEOPATHS, SERVING IN SOME 15 DIFFERENT PLACES IN IOWA. TOGETHER THEY SERVE EACH YEAR THOUSANDS OF PEOPLE WHO HAVE MEDICAL NEEDS.

ALTHOUGH INCREASES IN THE NUMBERS OF MEDICAL PERSONNEL HAVE HAD THE EFFECT OF MORE EQUITABLY DISTRIBUTING THEM ABOUT THE COUNTRY, IT IS PROBABLY THE CASE, AS YOU SAID IN YOUR OPENING STATEMENT, THAT SOME AREAS OF THE COUNTRY WILL ALWAYS BE UNDERSERVED, AND WE NEED A MECHANISM FOR ASSURING THAT PEOPLE IN THESE AREAS HAVE ACCESS TO APPROPRIATE MEDICAL CARE. THE NATIONAL HEALTH SERVICE CORPS ENABLES US TO ACCOMPLISH THIS.

AS I SAID IN MY STATEMENT AT THE FIRST HEARING IN THIS SERIES, THE BLOCK GRANTS HAVE WORKED WELL. THE EXCEPTION TO THIS IS THE PRIMARY CARE BLOCK GRANT WHICH AT THE PRESENT TIME HAS ONE PARTICIPANT, AND THAT PARTICIPANT IS NOT A STATE. IT SEEMS TO ME THAT ONE OF THE QUESTIONS WE HAVE TO ASK ABOUT THIS PROGRAM IS WHETHER STATE RELUCTANCE TO PARTICIPATE IS ATTRIBUTABLE EXCLUSIVELY TO THE RATHER LARGE MATCH REQUIRED BY THE BLOCK GRANT, OR WHETHER IT IS ATTRIBUTABLE ALSO, AT LEAST IN PART, TO STATE LACK OF EXPERIENCE WITH PRIMARY PROGRAMS AND A RESULTING LACK OF CAPACITY TO ADMINISTER THEM. FURTHERMORE, REPRESENTATIVES OF COMMUNITY HEALTH CENTERS HAVE EXPRESSED CONCERN THAT STATE GOVERNMENTS MIGHT NOT PLACE A HIGH PRIORITY ON THIS PROGRAM AND EVENTUALLY MIGHT REDUCE SERVICES WHICH THE CENTERS OFFER. WE SHOULD TRY TO DETERMINE TODAY WHETHER THIS IS CONCERN IS WELL-PLACED.

The CHAIRMAN. We will now proceed to our first panel who will testify on the prevention block grant legislation. We are happy at this time to welcome the witnesses from the General Accounting Office: Mr. Richard Fogel, Director of the Human Resources Division will testify regarding GAO's review of State implementation of the preventive health services and the alcohol, drug abuse and mental health block grants. Accompanying Mr. Fogel are Mr. William Gadsby, Mr. Gene L. Dodaro, Mr. Dan Lesch, and Mr. William Bidwell.

Mr. John Tierney, deputy director of the Rhode Island Department of Health, will testify regarding the health services, preventive health services at home, and Community Based Services Act of 1984. Mr. Tierney will be representing the Association of State and Territorial Health Officials.

We want to welcome all of you to the Senate, and we look forward to having your testimony at this time.

Mr. Fogel, we will turn to you.

STATEMENT OF RICHARD FOGEL, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY J. WILLIAM GADSBY, GENE L. DODARO, DAN LOESCH, WILLIAM BEDWELL, AND JOHN TIERNEY

Mr. FOGEL. Thank you, Mr. Chairman. We have submitted detailed statements on both the preventive health and the alcohol, drug abuse and mental health block grants, and if they could be inserted in the record, I would like to just read a brief summary statement.

The CHAIRMAN. Well, we appreciate summaries. Without objection, we will place the prepared statements of all witnesses in the record as though fully delivered.

Mr. FOGEL. Thank you very much.

By way of background, the General Accounting Office has undertaken an extensive study of all of the block grants that were enacted by the Congress in 1981, and we are pleased to be here today to discuss the implementation of the preventive health and health services and alcohol, drug abuse, and mental health block grants.

To do this work, we visited 13 States during the past year: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington, to examine a wide range of issues that were of interest to your committee as well as to other committees of the Congress.

Our testimony today focuses on four major areas: States' acceptance of their expanded management role; funding trends in State preventive health and alcohol, drug abuse, and mental health programs between 1981 and 1983; changes in services since block grant implementation; and perceptions about the block grant from State officials and interest groups.

I would like to highlight our observations, and my remarks will focus mostly on the preventive health block grant, but we will have some observations on the alcohol, drug abuse, and mental health block grant also.

In terms of the preventive health block grant, the 13 States generally assigned block grant responsibilities to State officials which had administered the prior categorical programs and made only minimal changes to their organizations or the structure of the service provider network. The States were taking their expanded administrative role seriously, and grant management activities were often integrated with ongoing State efforts for other related programs. While we were not able to quantify the cost savings associated with using the block grant approach, there were numerous indications from the State officials of administrative simplifications.

States were also obtaining input for making decisions on how to use the block grant funds from several sources, including hearings and advisory groups. Program officials also noted that Governors and State legislators were becoming more involved in program decisions. And, I might add, that the same trends were also true for the alcohol, drug abuse and mental health block grant.

As States implemented their new responsibilities, a central concern was attempting to maintain funding for preventive health programs. Trends in total expenditures for preventive health program areas varied considerably among the States. For the 11 States that have administered the block grant since October of 1981, total expenditures increased in 6 between 1981 and 1983, and declined in 5. New York and California, which began block grant administration in July 1982, both increased total expenditures between 1982 and 1983, bringing the number of States with increases in total expenditures to 8 of 13. However, after adjusting for inflation, total expenditures for preventive health programs increased in only 3 of the 13 States.

The variations in total expenditures occurred even though each State received a 12-percent reduction in Federal funds in 1982. This was primarily due to ongoing outlays from prior categorical awards and increases in State funding.

Ongoing categorical outlays were an important source of preventive health funds. Categorical funds comprised 61 percent of total 1982 expenditures of both categorical and block grant funds in the 10 States where we were able to get complete data, and still accounted for 11 percent of total expenditures in 1983. They helped offset reduced Federal appropriations and enabled States to carry an average of 43 percent of their 1982 preventive health block grant funds into 1983.

Eight of the 11 States administering the preventive health block grants between 1981 and 1983 increased the expenditure of related State funds, as did New York and California between 1982 and 1983. Eight of the 10 States that increased State expenditures also experienced growth in total expenditures.

While trends in total expenditures were mixed, States reported that the types of services offered under the preventive health grant were essentially the same as under the categorical programs. However, States did modify certain program priorities. Generally, States gave higher priority to program areas where they previously had greater involvement in making funding and program decisions.

They had had considerable prior involvement in health incentive, hypertension, fluoridation, and health education and risk reduction categorical programs. Although there were variations across the 13

States, the percentage of total expenditures for these program areas was generally maintained or increased. Also, States found little reason to adjust the types of services provided in these four program areas.

In contrast, States historically have had more limited control over Federal emergency medical services and rodent control programs, and under the block grant many assigned these program areas a lower priority and initiated more changes in services.

Many of our observations on the alcohol, drug abuse and, mental health block grant, are similar to what we found for the preventive health block grant. States were taking their new management role seriously, and the need to make major organizational or administrative changes was obviated by the State's prior involvement in categorical programs and other related State activities. Ongoing outlays for the prior categorical programs as well as increases in State support contributed to overall increases in total financial support for alcohol, drug abuse and mental health programs. And indeed, in the nine States where complete data was available 70 percent of the 1982 funds spent were categorical moneys and that enabled 60 percent of the 1982 block grant funds to be carried over into 1983. Eight of the nine States increased total support for this program between 1981 and 1983, even though Federal appropriations declined by 21 percent. Few changes were made concerning the types of services offered.

In conclusion, almost all State executive and legislative branch officials that we interviewed liked the increased flexibility and reduced administrative requirements under both block grants. Generally, they viewed the block grant as a more desirable way to fund preventive health and alcohol, drug abuse and mental health services than the prior categorical approach.

On the other hand, about half of the interest group respondents tended to view the block grant as a less desirable funding approach. While interest groups and State officials had differing views, both expressed concern about the Federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages.

My staff and I would be pleased to respond to questions after Mr. Tierney gives his statement.

[The prepared statement of Mr. Fogel follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 10:00 a.m.
March 7, 1984

STATEMENT OF
RICHARD L. FOGEL, DIRECTOR
HUMAN RESOURCES DIVISION

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

STATE IMPLEMENTATION OF THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT

Mr. Chairman and Members of the Committee;

We are pleased to be here today to discuss the implementation of the alcohol, drug abuse and mental health block grant. During the past year we have visited 13 states (California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington) to examine a wide range of issues that were of interest to your committee as well as other committees of the Congress. These states include a diverse cross section of the country and account for about 46 percent of the national alcohol, drug abuse, and mental health block grant appropriations and about 48 percent of the nation's population. Our draft report, which is currently being prepared, should be available soon to the Committee. Today, I would like to focus on our preliminary observations in four areas

--states acceptance of their expanded management role,

--funding trends in alcohol, drug abuse and mental health programs between 1981 and 1983,

--state policy decisions associated with block grant implementation, and

--perceptions about the block grant from state officials and interest groups.

Before discussing our observations, it would be useful to highlight the historical federal and state roles in administering the alcohol, drug abuse and mental health programs because of their influence on state block grant implementation.

In the mental health area, federal policy was to assist the start-up of community-based mental health centers with federal support declining over time. As a result, most states were providing about two thirds of the overall financial support to community mental health centers when the block grant was enacted, and they had considerable influence over the direction of mental health programs. For example, California spent $355 million for community mental health programs in 1981 compared with about $18 million in federal categorical awards.

State agencies were also heavily involved in managing federal alcohol and drug abuse categorical programs. The drug programs funneled a major portion of their support through a single grant to state agencies which provided services in accordance with federally approved plans. Although most federal alcohol programs were project grants that by-passed the state, formula grants under one major program were made directly to and administered by the states.

This shared financial and administrative responsibility between the federal and state governments for alcohol, drug abuse and mental health programs provided an established planning and administrative framework for states to assume their expanded block grant management role and helps explain the absence of major state program policy changes.

STATES INVOLVED IN MANAGING PROGRAMS SUPPORTED WITH BLOCK GRANT FUNDS

All 13 states generally assigned alcohol, drug abuse and mental health block grant responsibilities to their state offices which had administered the prior categorical programs or similar state programs. Thus, states found it necessary to make only limited organizational changes. Also, states were taking their management role seriously by establishing program requirements, monitoring grantees, providing technical assistance, collecting data, and auditing funds. These efforts were often integrated with ongoing state efforts for other related programs.

While we were not able to quantify any cost savings associated with managing alcohol, drug abuse and mental health programs using the block grant approach, there were indications of administrative simplification. According to state officials, the block grant enabled 7 of the 13 states to reduce the time and effort involved in preparing grant applications and reporting to the federal government, 5 to change or standardize their administrative requirements, and 8 to improve the planning and budgeting process.

States were also obtaining advice for making decisions on how to use block grant funds from several sources. In addition to conducting the mandated legislative hearings and preparing required reports on the intended use of block grant funds, all 13 states held executive hearings on some aspect of the program and 9 states used advisory groups. Many program officials reported that input from advisory committees, together with informal consultations, often had the most influence on program decisions. Also, program officials in nine states noted that legislatures had become more involved in program decisions under block grants. In five states, the governor's level of involvement was also greater.

TRENDS IN OVERALL PROGRAM FUNDING SHOW INCREASES IN MOST STATES

The federal-state shared responsibility for financing alcohol, drug abuse, and mental health services helped ease states' transition to the block grant. However, it also made it very difficult to construct a complete picture of aggregate program funding in 1981 from state records because all federal mental health grants and many alcohol awards went directly to local entities, by-passing the states. Nevertheless, we were able to develop financial information for the 1981-83 period in 9 of the 12 states that began administering the block grant in October 1981, and in California which assumed responsibility for the block grant in July 1982 for the 1982-83 period.

Eight of the 9 states where complete data was available showed an increase in the total financial support for alcohol, drug abuse, and mental health programs. The increases varied considerably among the eight states, ranging from about 3 percent in Pennsylvania to about 24 percent in Texas. Only Kentucky showed a decrease in overall funding of about 8 percent during this period. Also, California decreased total financial support by less than one percent between 1982 and 1983. After adjusting for inflation, however, only 5 of the 10 states showed increases in total financial support.

The upward trend in total financial support for the program between 1981 and 1983 occurred during a period when federal support declined about 21 percent nationally. This was primarily due to two key factors, (1) carryover funds from categorical awards and (2) increases in state funding.

The carryover funds from categorical grant awards were an important source of financial support for alcohol, drug abuse and mental health programs during 1982 because the prior categorical programs had project grants with awards that extended well into 1982. Therefore, many service providers were able to fund much of their 1982 operations with categorical funds. The availability of these funds reduced the amount of block grant funds that states had to spend if they chose not to increase funding above the 1981 levels.

For the nine states where complete data was available, categorical funds comprised about 70 percent of the total federal categorical and block grant funds used to support alcohol, drug abuse and mental health programs in 1982. Because categorical and block grant funding overlapped, the immediate impact of federal appropriation reductions was mitigated, and these states were able to carry about 60 percent of their 1982 alcohol, drug abuse and mental health block grant awards into 1983.

All nine states with complete data also increased their contribution to the overall alcohol, drug abuse and mental health program funding between 1981 and 1983. These increases ranged from 2 percent in Pennsylvania to 63 percent in Kentucky. For California, expenditures of state funds in 1983 were about one percent less than in 1982.

While the rise in state funds generally contributed to overall increases between 1981 and 1983, changes for each program component varied considerably. Total funding increased for mental health programs in 8 of the 9 states where complete data was available while remaining constant in one state. At the same time, total funding for alcohol programs increased in six states, remained constant in one and decreased in two. In contrast, drug abuse total funding decreased in six states and increased in three. The more frequent funding reductions in the drug area stem, in part, from states' heavier dependence on federal support to operate these programs.

LIMITED CHANGES MADE TO TYPES OF SERVICES

While trends in expenditures varied among the program areas, states did not make substantial changes to the kinds of services offered or to the network of service providers.

Generally, the services offered in 1983 were the same as those available under the categorical programs. However, five states reported that more emphasis was placed on alcohol prevention and early intervention programs. In the drug area, more emphasis was being placed on prevention activities in three states. In the mental health area, four states reported that more emphasis was being placed on outpatient programs for the chronically mentally ill, follow-up on patients released from mental institutions, and community-based residental care.

Alcohol, drug abuse and mental health services have typically been provided by non-profit organizations, hospitals, and local governmental agencies. None of the 13 states had made changes in the types of organizations eligible for funds under the block grant, and the network of providers which had received the categorical grants remain the principal recipients of block grant monies. It appears that the long standing co-sponsorship of many of the same service providers, coupled with fairly stable funding enabled the states to maintain the structure of the service provider network.

CONSIDERABLE CHANGE OCCURRING AT SERVICE PROVIDER LEVEL

Although the states made few policy changes affecting the types of services offered, a wide range of changes were occurring at the 47 service providers we visited. Each of these providers was unique. They had been in business for different lengths of time, served unique local needs, and were supported by different funding sources.

About two-thirds of the service providers had experienced total funding increases between 1981 and 1983. Typically the amount of federal funds had decreased while state and local funds increased. About half the providers had increased staffing levels where as the other half had staffing decreases. Only one provider had a constant level of staffing.

At most of the service providers visited, officials reported they were serving the same population groups which had been served under the categorical program. Also, about 60 percent of the providers told us that the number of clients served had increased whereas about 35 percent reported that clients served had decreased. Again, as expected, providers offering drug services tended to experience decreases in the number of clients served more often than did alcohol or mental health providers.

In certain instances clinics were making operational changes to increase their income or adapt to expected cuts in both federal and state program support. For example, a large clinic in New York was buying the building it had occupied under a lease arrangement. That option offered a lower operating cost and the unused space could be rented out to increase income as well. Additionally, this New York clinic had raised its fee charged for methodone maintenance treatment from $5.00 a week per client in 1981 to $10.00 a week in 1983, although, according to clinic officials, those unable to pay were still provided services.

In another instance, a county clinic in Colorado chose to spin-off a clinic providing alcohol services in a rural area into a nonprofit organization. Officials believed that several services offered could be marketed profitably and the type of services and their geographic coverage could be expanded as well.

Not all clinics visited seemed to be coping with funding changes as well as these. For example, a community mental health center in Mississippi, saw its total funds reduced by about 40 percent between 1982 and 1983. According to center officials, staff had been reduced by about one half and the center was serving 22 percent fewer clients.

While a variety of changes were occurring at the service providers visited, they were not solely attributable to the block grant. Instead they resulted from an array of factors which influenced their operations including program dynamics and changes in other sources of funds.

OVERALL PERCEPTIONS OF BLOCK GRANT DIFFER

Almost all state executive and legislative branch officials liked the increased flexibility and reduced administrative requirements offered under the block grant. Generally, they viewed it as a more desirable way to fund alcohol, drug abuse and mental health services than the prior categorical approach. On the other hand, about 49 percent of the interest group respondents tended to view the block grant as a less desirable funding approach while 26 percent viewed it as more desirable. The remaining 25 percent perceived no major difference.

While interest groups and state officials had differing views, both expressed concern about the federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages. It was often difficult, however, for individuals to separate block grants--the funding mechanism--from block grants--the budget cutting mechanism.

The CHAIRMAN. We will be happy to get into questions in a few minutes.

Let's turn to you, Mr. Tierney, and get your testimony on, and then I will turn to questions.

Mr. TIERNEY. Senator, it is my pleasure to be here today and have the opportunity to testify. I am speaking on behalf of the Rhode Island Department of Health and the Association of State and Territorial Health Officials.

In general, we both support all the programmatic elements in S. 2301, as indicated in my printed testimony filed with your staff.

The preventive block grant is most important to public health. Rhode Island receives $400,000 a year and adds $200,000 of State money for health promotion. The entire $600,000 goes directly into health promotion activities. The department of health conducts two major health promotion programs, one for children and one for adults. The program for children is operated through the State school systems. The purpose is to give children basic knowledge so they can make healthy lifestyle decisions. The program consists of integrated learning modules in grades K through 12.

In the past 3 years the department of health programs in the schools have been provided in 12 school systems, 79 schools; 1,690 teachers have participated; and 42,000 children have participated.

The department of health has developed a computerized health risk assessment program for teenagers 13 to 17. The system, including the software, is given free to every school system. A feature of the program is the capability to develop a profile for each group, grade, school or system, and to compare their lifestyle with similar populations.

From the data we can tailormake a health education program based on demonstrated need. To date we have a profile on over 5,000 Rhode Island teenagers.

Within 18 months the system will be in most schools in the State.

We also hope to create a climate among school systems to achieve healthier lifestyles, as has been done in sports and academics.

A similar health hazard appraisal and health risk reduction system has been designed for adults. The purpose is to increase their level of awareness about health risks and how to lessen them. Through the Wellness Wagon, over 30,000 Rhode Islanders have been evaluated by this system. It is now being tested in West Germany, in Canada, and almost a hundred universities and health departments, hospitals, health maintenance organizations, and doctors offices in this country.

Mr. Chairman, I believe that we are winning the battle for improved health behavior. Fewer people are smoking cigarettes, more are exercising, more have their blood pressure under control, more are eating healthier diets, more are wearing seat belts, fewer are dying from coronary heart disease, and drunk drivers are being caught.

We should increase our efforts and the resources allocated to health promotion. We spend about $1,400 per capita for curative services in this country, and small change for prevention. We spend billions in looking for the causes of cancer and heart disease and in caring for these patients, and yet we know that smoking causes disease in 30 percent of the victims.

Let's take a lesson from public health history. Dr. Lind, the Scottish naval surgeon, did not know about vitamins or the etiology or the physiology of scurvy. He noted that sailors on ships for long periods of time who did not eat citrus fruits had their teeth fall out and came down with scurvy. He then showed how oranges and lemons cured the disease.

Dr. John Snowe of London did not know about the cause of cholera nor the microorganism involved. He noted people drinking from a certain water system got sick and died at a much greater rate than those drinking from other water systems. So he took the handle off the Broad Street pump and cured an epidemic.

Please help the public health workers of this country take the handle off the pump.

The Association of State and Territorial Health Officials suggests that rather than $89 million for the preventive block grant in 1985, it be changed to 50 cents per capita, which would amount to $115 million in 1985, and then in 1986, $120 million, and in 1987, $125 million.

On behalf of the Rhode Island Department of Health and the Association of State and Territorial Health Officials, I appreciate the opportunity to testify here today and urge all of you to adopt the motto of the Rhode Island Department of Health, "Take care of yourself."

[The prepared statement of Mr. Tierney and responses to questions submitted by Senator Hatch follows:]

TESTIMONY OF

JOHN T. TIERNEY
DEPUTY DIRECTOR OF HEALTH
FOR THE
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

MR. CHAIRMAN:

MY NAME IS JOHN TIERNEY AND I AM THE DEPUTY DIRECTOR OF HEALTH FOR THE STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS. I AM ALSO THE CHAIRMAN OF THE MANAGEMENT COMMITTEE OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS. I AM PLEASED TO APPEAR BEFORE THIS COMMITTEE AND TO PRESENT THE VIEWS OF THE RHODE ISLAND DEPARTMENT OF HEALTH AND THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS.

MY REMARKS ARE ADDRESSED TO S:2301, HEALTH SERVICES, PREVENTIVE HEALTH SERVICES AND HOME AND COMMUNITY-BASED SERVICES ACT OF 1984, AS PUBLISHED IN THE FEBRUARY 9, 1984, CONGRESSIONAL RECORD.

THE STATE HEALTH DIRECTORS APPRECIATE THE FLEXIBILITY PROVIDED BY THE BLOCK GRANTS. WHILE HEALTH DEPARTMENTS ARE TRYING TO DO MORE WITH LESS RESOURCES, THIS METHOD OF FINANCING IS WORKING SUCCESSFULLY.

EVEN THOUGH RHODE ISLAND DID NOT HAVE FEDERAL RODENT CONTROL FUNDS IN THE BASE YEAR, MONEY FROM THE PREVENTIVE HEALTH BLOCK GRANT HAS BEEN ALLOCATED FOR THIS IMPORTANT ACTIVITY.

FLUORIDATION ACTIVITIES ARE FINANCED WITH STATE AND LOCAL FUNDS, AND 81 PERCENT OF THE POPULATION ARE SERVED BY FLUORIDATED WATER SUPPLIES, FLUORIDE RINSE PROGRAMS, OR SUPPLEMENTS.

THE RHODE ISLAND DEPARTMENT OF HEALTH IS MOST PROUD OF THE MONEY AND PERSONNEL DEVOTED TO COMPREHENSIVE PROGRAMS DESIGNED TO DETER SMOKING AND THE USE OF ALCOHOLIC BEVERAGES AMONG CHILDREN AND ADOLESCENTS AND OF OUR OTHER RISK REDUCTION AND HEALTH EDUCATION PROGRAMS. THE CORNERSTONE OF THESE ACTIVITIES IS THE $400,000 FROM THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TO WHICH THE STATE OF RHODE ISLAND CONTRIBUTES AN ADDITIONAL $200,000.

THIS YEAR, THE RHODE ISLAND ACCIDENT PREVENTION PROGRAM PROVIDES SAFETY EDUCATION LESSONS ON A ROTATING BASIS TO PUBLIC SCHOOL CHILDREN IN GRADES K-3 IN TWO RHODE ISLAND COMMUNITIES. PRESENTATIONS ARE GIVEN BY "SPECIALISTS" IN THEIR PARTICULAR FIELDS OF EXPERTISE AS AN INTRODUCTION TO THAT TOPIC. THESE LESSONS ARE THEN REINFORCED BY A STATE HEALTH DEPARTMENT RESOURCE TEACHER. IN ADDITION, THE CLASSROOM TEACHER IS GIVEN RESOURCE MATERIALS PROVIDED BY THE DEPARTMENT TO FACILITATE A THIRD REVIEW OF THE SUBJECT MATTER. THE EVALUATION CONSISTS OF PRE-TESTING AND POST-TESTING SECOND AND THIRD GRADE STUDENTS TO MEASURE THE EXTENT OF THEIR LEARNING THROUGH THE PROGRAM. FOR THIS 3-YEAR PERIOD, 20,000 CHILDREN HAVE RECEIVED ACCIDENT PREVENTION INSTRUCTION.

THE RHODE ISLAND COMMUNITY SMOKING AND ALCOHOL PROJECT CONSISTS OF COMPREHENSIVE AND COORDINATED HEALTH EDUCATION PROGRAMS FOR CHILDREN IN GRADES K THROUGH 12. THE ORGANIZATIONAL STRUCTURE CONSISTS OF THE FOLLOWING INTEGRATED MODULES:

K-3 - THE PROVIDENCE PLAN FOR IMPROVED HEALTH AND NUTRITION IS A COMPREHENSIVE HEALTH PROGRAM INTEGRATED INTO EXISTING CLASSROOM CURRICULA.

4-6 - THE SCHOOL HEALTH CURRICULUM OR "BERKELEY" PROJECT CONTINUES TO DEVELOP KNOWLEDGE, SKILLS, AND ATTITUDES ABOUT THE STRUCTURE AND FUNCTION OF THE HUMAN BODY.

7-8 - SUBSTANCE USE/ABUSE EDUCATION IS PRESENTED TO JUNIOR HIGH STUDENTS TO INCREASE SELF ESTEEM, DECISION-MAKING SKILLS, AND KNOWLEDGE ABOUT DRUGS, SMOKING AND ALCOHOL.

9-12 - STUDENT SEMINARS REGARDING THE INHERENT DANGERS OF SMOKING AND ALCOHOL ARE CONDUCTED.

THE SUCCESS OF THE PROJECT CAN BEST BE MEASURED THROUGH A NATIONAL EVALUATION OF SCHOOL HEALTH CURRICULA CONDUCTED BY ABT ASSOCIATES, INC. PRELIMINARY RESULTS FROM FIRST-YEAR "BERKELEY" DATA INDICATE SIGNIFICANT INCREASES ATTRIBUTABLE TO THE PROGRAM IN 10 KNOWLEDGE AREAS. IN ADDITION, PROGRAM PARTICIPATION IS ASSOCIATED WITH LARGE INCREASES IN DECISION-MAKING SKILLS. PARENTS REPORTED CHANGES IN THEIR OWN BEHAVIOR (PARTICULARLY SMOKING REDUCTION OR CESSATION) AS OFTEN AS THEY REPORTED CHANGES IN CHILD BEHAVIOR (OVER 9,000 PARENTS RESPONDED TO THE SURVEY).

IN ITS 3-YEAR LIFE, THIS PROGRAM WILL HAVE BEEN INSTITUTED IN 12 SCHOOL SYSTEMS AND 79 SCHOOLS. APPROXIMATELY 1,690 TEACHERS AND 42,000 STUDENTS WILL HAVE BEEN EXPOSED TO THIS CURRICULA.

MOST PEOPLE REALIZE THAT A HEALTHY LIFESTYLE - REGULAR EXERCISE, A NUTRITIOUS DIET, NO SMOKING - IS "GOOD" FOR THEM, BUT, ALL TOO OFTEN, THEY DON'T DO ANYTHING ABOUT IT.

THE PROBLEM IS THAT, WHILE PEOPLE MAY VAGUELY RECOGNIZE THE HEALTH DANGERS POSED BY CIGARETTE SMOKING AND THE LACK OF EXERCISE, THEY ARE NOT SO QUICK TO SEE THE DANGER OF THESE HABITS IN THEIR OWN LIVES.

THE PREVENTIVE HEALTH BLOCK GRANT HELPED THE RHODE ISLAND DEPARTMENT OF HEALTH TO DEVELOP A COMPUTERIZED HEALTH RISK APPRAISAL PROGRAM CALLED WELLNESS CHECK. THE PROGRAM IS DESIGNED TO MAKE INDIVIDUALS MORE AWARE OF THE DIFFERENCE "HEALTH RISKS" CAN MAKE IN THEIR LIVES.

THIS IS HOW WELLNESS CHECK WORKS. THE INDIVIDUAL COMPLETES A QUESTIONNAIRE COVERING A RANGE OF LIFESTYLE TOPICS. THE QUESTIONNAIRE RESPONSE CARD IS FED INTO A CARD READER LINKED TO A COMPUTER, AND, ALMOST IMMEDIATELY, THE RESPONDENT RECEIVES AN INDIVIDUALIZED PRINTOUT REPORT, ASSESSING THE INDIVIDUAL'S HEALTH "PROGNOSIS" - BASED ON CURRENT LIFESTYLE HABITS - AND OFFERING ADVICE ON HOW TO REDUCE HEALTH RISKS OUTLINED IN THE APPRAISAL REPORT. PARTICIPANTS ALSO RECEIVE A BOOKLET, THE WAY TO WELLNESS, TO GUIDE THEM IN DEALING WITH THESE HEALTH RISKS.

THE HEALTH DEPARTMENT HAS PRIMARILY USED WELLNESS CHECK IN CONJUNCTION WITH THE "WELLNESS WAGON", A MICROCOMPUTER-EQUIPPED VAN THAT HAS PROCESSED HEALTH RISK APPRAISALS FOR MORE THAN 30,000 RHODE ISLANDERS SINCE THE PROGRAM BEGAN IN 1980. THE "WELLNESS WAGON" HAS TRAVELED THROUGHOUT THE STATE, VISITING INDUSTRIAL PLANTS, COLLEGES, SHOPPING MALLS, HEALTH FAIRS AND OTHER PUBLIC LOCATIONS.

WHILE WELLNESS CHECK IS PRIMARILY DESIGNED AS AN EDUCATIONAL TOOL TO DRAMATIZE THE IMPORTANCE OF HEALTHY LIVING HABITS IN AVOIDING ILLNESS AND INJURY, IT ALSO ASSISTS THE COMMUNITY IN IDENTIFYING ITS PREDOMINANT HEALTH PROBLEMS.

SINCE ITS DEVELOPMENT, WELLNESS CHECK HAS BEEN NATIONALLY RECOGNIZED AS A UNIQUE AND EFFECTIVE HEALTH PROMOTION PROGRAM. IT WAS FEATURED IN THE NOVEMBER 1980 HEALTH PLANNING NEWSLETTER OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND, IN APRIL 1982, AT A NATIONAL CONSUMERS WEEK PROGRAM IN WASHINGTON, D.C., AT THE INVITATION OF THAT DEPARTMENT. IT IS AN IMPORTANT PART OF THE RHODE ISLAND DEPARTMENT OF HEALTH'S "HEALTH EDUCATION-RISK REDUCTION PROGRAM" SELECTED AS A NATIONAL MODEL BY THE FEDERAL CENTERS FOR DISEASE CONTROL.

THE PROGRAM HAS PROVED SO SUCCESSFUL THAT IT HAS BEEN INTRODUCED IN A NUMBER OF OTHER STATES, AS WELL AS FOREIGN NATIONS, AND HAS BEEN TRANSLATED FOR USE BY THE SPANISH-SPEAKING COMMUNITY.

THE FORMATION OF HEALTHY LIVING HABITS IS ESPECIALLY IMPORTANT FOR YOUNG PEOPLE. TOWARD THIS OBJECTIVE, THE RHODE ISLAND DEPARTMENT OF HEALTH HAS SUPPLEMENTED ITS WELLNESS CHECK PROGRAM FOR ADULTS (AGE 18 AND OVER) WITH A COMPANION PROGRAM FOR TEENAGERS FROM 13 TO 17 YEARS OF AGE.

WHILE THE TEENAGE VERSION INCLUDES SOME OF THE SAME HEALTH RISK CATEGORIES (SMOKING, PHYSICAL FITNESS, ETC.) AS THE ADULT VERSION, IT ALSO FEATURES OTHER CATEGORIES ESPECIALLY APPROPRIATE FOR THE YOUNGER GROUP, SUCH AS "SEXUALITY" AND"MARIJUANA AND OTHER DRUGS." THE TEENAGE VERSION OFFERS A BOOKLET COVERING TOPICS PARTICULARLY RELEVANT TO THIS AGE GROUP AND WRITTEN IN A STYLE SUITED TO THE TEENAGE READER.

SO FAR, ALMOST 5,000 RHODE ISLAND TEENAGERS HAVE PARTICIPATED IN THIS PROGRAM. THE PROGRAM'S COMPUTER SOFTWARE AND EDUCATIONAL MATERIALS ARE BEING PROVIDED TO EVERY HIGH SCHOOL IN THE STATE TO HELP EACH SCHOOL SYSTEM DESIGN HEALTH EDUCATION PROGRAMS THAT MEET ITS PARTICULAR NEEDS. ON A DAILY BASIS, AN IMMEDIATE PROFILE FOR THE INDIVIDUALS PROCESSED CAN BE PRODUCED AND COMPARED WITH OTHER SIMILAR GROUPS IN THE DATA BASE.

WHILE THE MAIN PURPOSE OF THE PROGRAM IS TO PERSUADE THE YOUNG PARTICIPANTS TO ADOPT HEALTHIER LIFESTYLE HABITS, THE PROGRAM ALSO SERVES AS A VALUABLE RESEARCH TOOL FOR SCHOOL ADMINISTRATIVE STAFF WITH RESPONSIBILITIES FOR SCHOOL HEALTH.

WELLNESS CHECK HEALTH RISK APPRAISALS AMONG RHODE ISLAND TEENAGERS HAVE SHOWN THAT:

* ALMOST ONE-THIRD DON'T GET 20 MINUTES OF HEALTHY EXERCISE AT LEAST THREE TIMES A WEEK.

* ONE QUARTER CATEGORIZE THEMSELVES AS REGULAR CIGARETTE SMOKERS.

* 12 PERCENT SAID THEY CONSUME SEVEN OR MORE ALCOHOLIC DRINKS WEEKLY, AND 20 PERCENT SAID THEY "SOMETIMES/OFTEN" DRIVE OR RIDE WITH A DRIVER UNDER THE INFLUENCE OF ALCOHOL.

* ALMOST 70 PERCENT SAID THEY NEVER WEAR A SEAT BELT WHILE TRAVELING IN AN AUTOMOBILE AND, AMONG THE FEMALE RESPONDENTS, 86 PERCENT SAID THEY DON'T PRACTICE BREAST SELF-EXAMINATION ON A MONTHLY BASIS, AS RECOMMENDED BY THE AMERICAN CANCER SOCIETY.

* DESPITE ALL THE PUBLICIZED INCIDENTS OF VIOLENT CRIMES ASSOCIATED WITH IT, 19 PERCENT OF THE TEENAGERS SAID THEY HITCHHIKE AT LEAST OCCASIONALLY. OVER 12 PERCENT OF THE GIRLS SAID THEY HITCHHIKE "SELDOM, SOMETIMES, OR OFTEN."

THE WELLNESS CHECK PROGRAM IS INTENDED TO CONVINCE TEENAGE PARTICIPANTS THAT, EVEN AT A YOUNG AGE, HEALTHY LIVING HABITS ARE IMPORTANT; AND TO PERSUADE THEM TO ACT UPON THAT CONVICTION.

THE RHODE ISLAND DEPARTMENT OF HEALTH OFFERS A COMPREHENSIVE VARIETY OF EMPLOYEE RISK REDUCTION SERVICES TO RHODE ISLAND'S INDUSTRY. A NETWORK OF COMMUNITY RESOURCES IS COORDINATED TO PROVIDE RISK REDUCTION PROGRAMS LIKE SMOKING CESSATION, FITNESS, NUTRITION AND STRESS REDUCTION CLASSES AT THE WORKSITE. THE WELLNESS CHECK HEALTH RISK APPRAISAL INSTRUMENT IS USED TO PROVIDE THE INITIAL EMPLOYEE HEALTH PROFILE AND TO PLAN APPROPRIATE PROGRAMS. A BROCHURE HAS BEEN DEVELOPED TO PROMOTE THE PROGRAM AND MEETINGS HAVE BEEN HELD WITH OVER 20 COMPANIES.

THE RHODE ISLAND DEPARTMENT OF HEALTH WITH PREVENTIVE BLOCK GRANT MONIES CONDUCTS A STATEWIDE HYPERTENSION CONTROL PROGRAM TARGETING HIGH RISK POPULATIONS AT THE WORKSITE. THE PROGRAM INVOLVES A CONTRACT WITH THE AMERICAN HEART ASSOCIATION, RHODE ISLAND AFFILIATE, TO CONDUCT A SERIES OF WORKSHOPS DESIGNED TO TRAIN REPRESENTATIVES OF WORKSITES IN HOW TO OPERATE AN ONGOING HYPERTENSION TRACKING AND MAINTENANCE SYSTEM FOR EMPLOYEES. EMPLOYERS PARTICIPATING IN THE PROGRAM SUBMIT DETAILED QUARTERLY REPORTS OF STATISTICS TO THE HEART ASSOCIATION. 25 WORKSITES, INCLUDING THE RHODE ISLAND DEPARTMENT OF HEALTH, MOST WITH OVER 250 EMPLOYEES, HAVE COMPLETED WORKSHOP TRAINING.

THE RHODE ISLAND DEPARTMENT OF HEALTH CONTRACTS WITH PROVIDENCE HEALTH CENTERS TO CONDUCT A HYPERTENSION SCREENING AND FOLLOW-UP PROGRAM FOR HEALTH CENTER USERS. THE CENTER SERVES THE POPULATION AT HIGHEST RISK OF SUFFERING FROM UNDETECTED OR UNCONTROLLED HYPERTENSION (POOR, BLACK, "NON-USERS" OR EPISODIC USERS OF HEALTH CARE). THE CENTER DOCUMENTS COMPLIANCE TO AN APPROPRIATE FOLLOW-UP REGIMEN FOR IDENTIFIED HYPERTENSIVES.

THE RHODE ISLAND DEPARTMENT OF HEALTH STAFF WORKS WITH COMMUNITY GROUPS TO DISTRIBUTE MATERIALS, CONDUCT PUBLIC AND SCHOOL EDUCATION CAMPAIGNS AND PARTICIPATE IN A VARIETY OF ACTIVITIES FOR MAY, HIGH BLOOD PRESSURE MONTH. THIS YEAR, BLACK CHURCHES ARE THE TARGET OF A SCREENING AND EDUCATION CAMPAIGN.

THE REMOVAL OF HYPERTENSION FROM SET-ASIDE FUNDS IS LAUDABLE AND IN KEEPING WITH THE PHILOSOPHY OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS OF MAXIMUM FLEXIBILITY AT THE OPERATING LEVEL.

ASTHO SUPPORTS THE REAUTHORIZATIONS FOR CHILDHOOD IMMUNIZATION, TUBERCULOSIS, AND SEXUALLY TRANSMITTED DISEASE PROGRAMS. WE WOULD NOTE, HOWEVER, ESPECIALLY IN THE CHILDHOOD IMMUNIZATION PROGRAM, THE COST OF VACCINES HAS GONE UP SO MUCH THAT INCREASINGLY, STATES ARE FORCED TO PUT UP LOCAL FUNDS FOR PERSONNEL AND PROGRAMMATIC SUPPORT. THE NATURE OF THESE HEALTH PROBLEMS IS SUCH THAT WE SHOULD NOT BE LULLED BY OUR SUCCESSES INTO DECREASING THE EFFORTS OR RESOURCES DEVOTED TO THESE IMPORTANT ISSUES. WE ALSO SUPPORT THE BEGINNING AND MODEST EFFORTS IN IMPROVING EMERGENCY MEDICAL SERVICE SYSTEMS FOR CRITICALLY ILL CHILDREN. WE MUST CONTINUALLY REMIND OURSELVES AND OTHERS THAT CHILDREN ARE NOT JUST SMALL ADULTS.

ASTHO CONTINUES ITS SUPPORT FOR A UNIFORM NATIONAL COMPENSATION SYSTEM FOR CHILDREN WHO ARE VICTIMS OF VACCINE-RELATED INJURIES, AND WE ARE PLEASED TO NOTE THAT THIS COMMITTEE WILL TAKE UP THIS INITIATIVE LATER IN THE SPRING.

WE ALSO SUPPORT PROGRAMS TO PREVENT RAPE AND TO PROVIDE SERVICES TO RAPE VICTIMS.

THE HOME AND COMMUNITY SERVICES SECTIONS OF S:2301 ARE TIMELY, EXCITING AND GENERALLY ON THE MARK. THESE SECTIONS PROMOTE COORDINATION, CASE-FINDING, VOLUNTEERISM, EDUCATION AND INFORMATION, ADULT DAY CARE, RESPITE CARE, CASE MANAGEMENT AND OTHER SUPPORTIVE SERVICES. THIS TYPE OF DEVELOPMENTAL PROGRAM IS ESSENTIAL IF WE ARE TO MEET THE FORMIDABLE CHALLENGE OF AN AGING POPULATION IN A COST/EFFECTIVE MANNER. CLEARLY, OUR CURRENT LONG-TERM CARE SYSTEM WHICH IS INSTITUTIONALLY-BASED MUST BE TRANSFORMED INTO A COMMUNITY-BASED SYSTEM IF WE WANT TO PROVIDE APPROPRIATE ACCESS TO HIGH QUALITY LONG-TERM CARE SERVICES AT A REASONABLE COST.

THERE ARE A NUMBER OF QUESTIONS ASSOCIATED WITH THE HOME AND COMMUNITY SERVICES SECTIONS WHICH ARE WORTH CONSIDERATION. FIRST, IS THERE A DANGER IN COMBINING PREVENTIVE HEALTH SERVICES AND LONG-TERM CARE SERVICES IN THE SAME BILL? IN THE LONG RUN, WILL PREVENTIVE HEALTH SERVICES BE ABLE TO HOLD THEIR OWN IN THE FACE OF A GROWING DEMAND FOR LONG-TERM CARE SERVICES? CERTAINLY, WE WOULD NOT WANT TO ERODE SUPPORT FOR PREVENTIVE HEALTH SERVICES. WHILE WE RECOGNIZE THAT PREVENTIVE HEALTH AND HOME HEALTH SERVICES HAVE SEPARATE TITLES, SHOULD THERE BE SOME PROVISION TO PROHIBIT TRANSFER BETWEEN PROGRAMS?

SECOND, SHOULD HOME AND COMMUNITY-BASED SERVICES BE TIED CLOSER TO THE MEDICARE AND MEDICAID PROGRAMS IN ORDER TO MINIMIZE FRAGMENTATION AND IN ORDER TO MAXIMIZE IMPACT? IN THE FINAL ANALYSIS, PROGRAM EFFECTIVENESS WILL DEPEND ON EFFECTIVE LINKAGES BETWEEN THESE THREE PROGRAMS.

THIRD, SHOULD STATES WHICH CURRENTLY HAVE A SUFFICIENT NUMBER OF HOME HEALTH AGENCIES BE ABLE TO ALLOCATE FUNDS FOR ESTABLISHING HOME HEALTH AGENCIES TO OTHER PREVENTIVE OR LONG-TERM CARE PURPOSES? SOME HEALTH PLANNING AGENCIES HAVE IDENTIFIED THE PROLIFERATION OF HOME HEALTH AGENCIES AS A BARRIER TO EFFICIENCY AND EFFECTIVENESS. THERE IS A SIGNIFICANT DIFFERENCE BETWEEN THE NEED FOR ADDITIONAL HOME HEALTH VISITS AND THE NEED FOR ADDITIONAL HOME HEALTH AGENCIES.

FINALLY, AND MOST IMPORTANTLY, THE STATES CAN PUT THE HOME AND COMMUNITY SERVICES SECTIONS OF S:2301 TO VERY GOOD USE. IT APPEARS THAT ALL OF THE FOLLOWING AGENDA ITEMS AND MORE COULD BE PURSUED UNDER SUCH AUTHORITY AND FINANCING:

- VERTICAL INTEGRATION OF HEALTH SERVICES,
- EMPHASIS ON A SOCIAL SERVICE APPROACH,
- LINKAGE OF AMBULATORY AND HOME-BASED SERVICES,
- DEVELOPMENT OF INNOVATIVE FINANCING PACKAGES FOR LONG-TERM CARE SERVICES,
- PROMOTION OF SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.

THUS, THE HOME AND COMMUNITY SERVICES SECTIONS OF S:2301 COULD BE VERY INSTRUMENTAL IN THE RESTRUCTURING OF LONG-TERM CARE SERVICES IN THE STATES. SUCH DEVELOPMENT FUNDS COULD HAVE A VERY POSITIVE IMPACT ON THE PACE AND DIRECTION OF CHANGE IN THE LONG-TERM CARE FIELD.

MR. CHAIRMAN:

I BELIEVE THE BATTLE FOR IMPROVED HEALTH BEHAVIORS IS BEING WON. FEWER PEOPLE ARE SMOKING CIGARETTES, MORE ARE EXERCISING, MORE HAVE THEIR BLOOD PRESSURE UNDER CONTROL, MORE ARE EATING HEALTHIER DIETS, MORE ARE WEARING SEAT BELTS, DEATHS FROM CORONARY HEART DISEASE ARE DRAMATICALLY DECREASING, AND DRUNKEN DRIVERS ARE BEING CAUGHT.

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS RECOGNIZES THAT WE AS A COUNTRY MUST SPEND RESOURCES ON RESEARCH FOR THE CAUSES OF CANCER AND HEART DISEASE AND PAYING FOR MEDICAL SERVICES PROVIDED TO CANCER AND HEART DISEASE AND ACCIDENT PATIENTS. WE FIND IT DIFFICULT TO RECONCILE WHY WE SPEND SO LITTLE ON THE PREVENTION OF CANCER WHEN WE KNOW THAT 30% IS CAUSED BY CIGARETTE SMOKING, WE KNOW THAT 30 PERCENT OF HEART DISEASE IS CAUSED BY CIGARETTES, AND ANOTHER 35 PERCENT OF CANCER IS CAUSED BY DIET, AND THAT SEAT BELTS DRAMATICALLY REDUCE DEATH AND INJURY FROM ACCIDENTS. WE BELIEVE WE CAN INTERVENE EFFECTIVELY NOW IF WE ARE GIVEN THE RESOURCES.

WE FIND IT DIFFICULT TO UNDERSTAND WHY THIS COUNTRY SPENDS ALMOST ONE THOUSAND FOUR HUNDRED DOLLARS PER CAPITA FOR CURATIVE SERVICES AND ONLY SMALL CHANGE FOR PREVENTION. WE SHOULD INCREASE SUPPORT OF PROGRAMS DEDICATED TO IMPROVING HEALTH BEHAVIOR, THOSE DESIGNED TO DETER SMOKING AND THE USE OF ALCOHOL AMONG CHILDREN AND ADOLESCENTS, AND OTHER RISK REDUCTION AND HEALTH PROMOTION PROGRAMS. WE URGE THAT THESE PROGRAMS SHOULD BE FUNDED AT A MINIMUM OF 50 CENTS PER CAPITA, WHICH AMOUNTS TO $115 MILLION IN 1985, $120 MILLION IN 1986, AND $125 MILLION IN 1987.

FINALLY, AN AREA OF GROWING CONCERN AMONG THIS COUNTRY'S STATE HEALTH OFFICERS AND AMONG MEMBERS OF CONGRESS IS THE NEED FOR NATIONAL, UNIFORM INFORMATION ON THE USES OF BLOCK GRANT FUNDS. ELABORATE AND BURDENSOME BLOCK GRANT REPORTING REQUIREMENTS ARE NEITHER NECESSARY NOR DESIRABLE; BUT MAINTAINING PUBLIC CONFIDENCE AND ADEQUATE FUNDING FOR THESE HIGHLY FLEXIBLE GRANTS HINGES ON THE STATES' ABILITY TO DESCRIBE IN NATIONAL, UNIFORM TERMS, THE VITAL SERVICES SUPPORTED BY BLOCK GRANT FUNDS. THE REPORTS REQUIRED BY PL 97-35 FAIL TO MEET THIS NEED BECAUSE THEY LACK UNIFORMITY, AND THUS, CANNOT BE AGGREGATED NATIONALLY.

HOWEVER, FOR THE LAST 12 YEARS, THE STATES HAVE OPERATED A VOLUNTARY, COOPERATIVE INFORMATION SYSTEM FOR THE EXPRESS PURPOSE OF PROVIDING THE KINDS OF UNIFORM DATA THAT ARE NOW BEING SOUGHT. THIS NATIONAL PUBLIC HEALTH PROGRAM REPORTING SYSTEM CURRENTLY PROVIDES COMPREHENSIVE, UNIFORM DATA ON STATE HEALTH AGENCY OPERATIONS, INDIVIDUALLY AND NATIONALLY, INCLUDING: HOW MUCH THEY SPEND, WHERE THEIR MONEY COMES FROM, WHAT KINDS OF SERVICES THEY PROVIDE, AND HOW MANY PEOPLE THEY SERVE. THE SURVEY INSTRUMENTS FOR THIS SYSTEM WERE EXTENSIVELY REVISED FOR THE FISCAL YEAR 1982 CYCLE TO ENABLE US TO TRACK AND ASSESS THE IMPACT OF THE BLOCK GRANTS. IN FACT, I HAVE WITH ME A SUMMARY OF SOME OF THE MOST SIGNIFICANT FINDINGS OF THE 1982 SURVEY THAT I WOULD BE PLEASED TO SUBMIT FOR THE RECORD.

IT IS MOST UNFORTUNATE THAT THE CONTINUED EXISTENCE OF THIS VOLUNTARY, COOPERATIVE SYSTEM IS CURRENTLY JEOPARDIZED BY A LACK OF FUNDING. FEDERAL FINANCIAL SUPPORT FOR THIS SYSTEM IS, TODAY, ROUGHLY HALF OF WHAT IT WAS FIVE YEARS AGO. THIS HAS CAUSED THE TIMELINESS OF OUR REPORTS TO SUFFER GREATLY; OUR 1982 REPORTS WILL BE PUBLISHED 9 TO 10 MONTHS LATER IN THE YEAR THAN WERE OUR 1980 REPORTS. THIS IS PARTICULARLY SIGNIFICANT WHEN CONSIDERED IN THE CONTEXT OF REAUTHORIZATION HEARINGS SUCH AS THESE. FOUR YEARS AGO, THE MEMBERS OF THIS COMMITTEE WOULD HAVE RECEIVED BOUND COPIES OF OUR FY 1982 REPORTS WELL BEFORE THE FIRST SESSION OF THIS CONGRESS ADJOURNED; AND I WOULD BE SITTING HERE TODAY WITH PRELIMINARY FY 1983 DATA IN HAND. INSTEAD, I HAVE TODAY A SUMMARY OF SOME OF OUR 1982 DATA IN HAND, WITH THE PUBLISHED REPORTS DUE OUT IN MAY OR JUNE. FOR THIS REASON, THE STATES APPLAUD THE WORK DONE BY GAO, FOR WITHOUT THEIR 13 STATE STUDY, THE CONGRESS WOULD HAVE PRECIOUS LITTLE INFORMATION ON THE 1983 USES OF BLOCK GRANT FUNDS.

BUT, UNLESS THE CONGRESS INTENDS FOR THE GAO TO GO INTO THE BUSINESS OF MAINTAINING A ROUTINE DATA COLLECTION SYSTEM, AND UNLESS THE CURRENT INFORMATION CRISIS IS TO BE REPEATED THE NEXT TIME THESE BLOCK GRANTS COME UP FOR REAUTHORIZATION, THIS COMMITTEE MUST TAKE SOME DEFINITIVE, PREVENTIVE ACTION. THEREFORE, THE ASTHO URGES YOU TO CONSIDER SETTING ASIDE ONE-HALF OF ONE PERCENT OF THE S:2301 BLOCK GRANT APPROPRIATION TO GET THE STATES' VOLUNTARY, COOPERATIVE SYSTEM BACK ON SOLID FOOTING.

IN SUMMARY, THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS SUPPORTS S:2301, THE HEALTH SERVICES, PREVENTIVE HEALTH SERVICES AND HOME AND COMMUNITY-BASED SERVICES ACT OF 1984. ADDITIONALLY, WE SUPPORT THE INCREASE IN AUTHORIZATIONS AND THE PROVISION TO ASSURE ONE-HALF OF ONE PERCENT OF THE APPROPRIATION FOR THE TABULATION AND ANALYSIS OF UNIFORM NATIONAL DATA VOLUNTARILY BEING REPORTED BY STATE AND TERRITORIAL HEALTH DEPARTMENTS.

I APPRECIATE THE OPPORTUNITY TO TESTIFY BEFORE YOU TODAY, AND URGE YOU TO CONTINUE YOUR STRONG ADVOCACY FOR HEALTH PROMOTION AND DISEASE PREVENTION.

State Health Department Use of PHHS and MCH Block Grant Funds, FY 1982

In FY 1982, 51 state health agencies (SHAs) reported service and expenditure information to the Association of State and Territorial Health Officials Foundation. These SHAs reported that $5.0 billion was spent to provide public health services to 62.6 million persons. SHA expenditures for public health services increased by 5 percent from 1981 to 1982; however, when the 1982 expenditures are adjusted for inflation, total expenditures decreased by 1.5 percent.

In the area of personal health programs, $3.7 billion was spent in fiscal year 1982. State funds accounted for $1.9 billion and $1.5 billion came from federal grants and contracts. When adjusted for inflation, this represented a 0.5 percent increase in state funds and a 6 percent decrease in federal grant and contract funds. The proportion of total personal health program expenditures represented by state funds increased from 50 percent in FY 1981 to 51 percent in FY 1982; while the proportion of these expenditures represented by federal grant and contract funds decreased from 42 percent to 40 percent.

Of the $1.5 billion in federal grant and contract funds spent for personal health programs, $19 million (1.3 percent) was from the Preventive Health and Health Services (PHHS) Block Grant and $139 million (9.5 percent) was from the Maternal and Child Health (MCH) Services Block Grant. The amount of block grant funds spent by the SHAs during their 1982 fiscal year period was rather small for several reasons. First, most states' 1982 fiscal year began in July 1981 but block grant funds were not available until October 1, 1981. The result being that block grant funding was available to most SHAs for a maximum of 9 months during their 1982 fiscal year. Second, some states (e.g., California and New York) did not assume control of the block grants during their 1982 fiscal year. Such states continued to receive a pro rata share of categorical funding. Finally, overlap existed between the budget periods of many of the categorical program that were included in the block grants, and the block grants themselves. As a result, significant sums of (federal) FY 1981 categorical funds were spent by the SHAs during their 1982 fiscal year. This enabled them to conserve a portion of their 1982 block grant allotments for expenditure the following year.

ASTHO's FY 1982 data provide no evidence that any of the individual programs that were heavily funded by categorical grants sustained a disproportionate share of the funding reductions that accompanied the block grants. Rather, most SHAs appear to have reduced program funding across the board on a pro rata basis. Certain SHAs did, however, take advantage of the flexibility inherent in the block grants to address unforseen public health emergencies. For example, in Virginia, PHHS Block Grant funds were a crucial resource in enabling the SHA to successfully respond to the worst outbreak of rabies in the state's history.

However, there is evidence that the reduction in federal funding accompanying the block grants did have an impact in two key areas: (1) the number of people served and (2) staffing levels. From 1981 to 1982, there was a 5 percent reduction in the total number of persons served by SHAs programs reporting comparable data. This represents a total of 2 million people who did not receive public health services in 1982. The SHAs also reported a 5 percent decrease (1.5 million persons) in the number of people screened for all diseases or health conditions.[1]

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[1] These data are based on approximately 60 percent of the universe of all individuals receiving any service or screening in 1982; thus, it is likely the actual reduction in the number of people served was substantially greater.

The ASTHO Foundation did not collect staffing data for 1982 but in 1981, a 0.4 percent decrease in inflation-adjusted expenditures was accompanied by a 2 percent reduction in personnel (1300 positions). The cuts fell most heavily on personal health programs, where a 5 percent reduction took place (representing 1100 positions). Extrapolating this relationship to 1982, it can be presumed that the 1.5 percent decrease in inflation-adjusted public health expenditures would likely be associated with either a further reduction or, at best, a freeze in staffing levels.

Q & A FOR SENATE TESTIMONY

SENATOR: MR. TIERNEY, WHAT, IF ANYTHING, IS UNIQUE ABOUT THIS VOLUNTARY STATE REPORTING SYSTEM OF WHICH YOU SPOKE?

MR. TIERNEY: SENATOR, FIRST, OUR SYSTEM IS A VOLUNTARY, COOPERATIVE EFFORT OF THE NATION'S STATE HEALTH AGENCIES. AS SUCH, THE DATA COLLECTED REPRESENT THE CONSENSUS OF THE STATES, RATHER THAN A SET OF INFORMATION DETERMINED AT ANOTHER LEVEL OF GOVERNMENT. IN ADDITION, OUR DATA COLLECTION UNIVERSE CONSISTS OF THE NATION'S 57 STATE AND TERRITORIAL HEALTH AGENCIES, MAKING OUR SYSTEM THE ONLY SUCH COMPREHENSIVE INFORMATION GATHERING EFFORT. FURTHER, WHILE OTHER STUDIES OF THE BLOCK GRANTS HAVE BEEN SOMEWHAT PROSPECTIVE IN NATURE, OFTEN DEALING WITH BUDGET FIGURES OR PROJECTED EXPENDITURES, OUR SYSTEM IS MORE GEARED TO ACCOUNTABILITY, DEALING IN ACTUAL EXPENDITURE FIGURES, COLLECTED AFTER THE CLOSE OF EACH STATE'S FISCAL YEAR.

A FINAL, UNIQUE ASPECT OF THE STATES VOLUNTARY SYSTEM IS THAT THE LARGEST PART OF OUR EFFORT IS AIMED AT OBTAINING QUANTATIVE DATA ON THE SERVICES PROVIDED BY STATE HEALTH AGENCIES. MOST OTHER STUDIES OF THE BLOCK GRANTS HAVE CONCENTRATED ON THE FISCAL SIDE ALONE. FOR EXAMPLE, AS A RESULT OF OUR FOCUS ON SERVICES WE HAVE BEEN ABLE TO DOCUMENT A DECLINE OF FIVE PERCENT (OR, ROUGHLY 2.8 MILLION PEOPLE) IN THE NUMBER OF PERSONS SERVED

BY STATE HEALTH AGENCIES FROM 1981 TO 1982. IT IS PARTICULARLY DISTURBING THAT, CONTRIBUTING TO THIS TOTAL, WAS A DECLINE OF ROUGHLY 2 MILLION IN THE NUMBER OF PERSONS SCREENED FOR ALL DISEASES AND HEALTH CONDITIONS. THAT FIGURE STRIKES AT THE HEART OF THIS NATION'S PREVENTIVE HEALTH STRATEGY.

Reporting System Language for Block Grant Testimony

Finally, an area of growing concern among this country's state health officers and among members of Congress is the need for national, uniform information on the uses of block grant funds. Elaborate and burdensome block grant reporting requirements are neither necessary nor desirable; but maintaining public confidence and adequate funding for these highly flexible grants hinges on the states' ability to describe in national, uniform terms, the vital services supported by block grant funds. The reports required by PL 97-35 fail to meet this need because they lack uniformity, and thus, cannot be aggregated nationally.

However, for the last 12 years, the states have operated a voluntary, cooperative information system for the express purpose of providing the kinds of uniform data that are now being sought. This national public health program reporting system currently provides comprehensive, uniform data on state health agency operations, individually and nationally, including: how much they spend, where their money comes from, what kinds of services they provide, and how many people they serve. The survey instruments for this system were extensively revised for the FY 1982 cycle to enable us to track and assess the impact of the block grants. In fact, I have with me a summary of some of the most significant findings of the 1982 survey that I would be pleased to submit for the record.

It is most unfortunate that the continued existence of this voluntary, cooperative system is currently jeopardized by a lack of funding. Federal financial support for this system is, today, roughly half of what it was five years ago. This has caused the timeliness of our reports to suffer greatly: our 1982 reports will be published 9 to 10 months later in the year than were our 1980 reports. This is particularly significant when considered in the context of reauthorization hearings such as these. Four years ago, the members of this Committee would have received bound copies of our FY 1982 reports well before the first session of this Congress adjourned; and I would be sitting here today with preliminary FY 1983 data in hand. Instead, I have today a summary of some of our 1982 data in hand, with the published reports due out in May or June. For this reason, the states applaud the work done by GAO, for without their 13 state study, the Congress would have precious little information on the 1983 uses of block grant funds.

But, unless the Congress intends for the GAO to go into the business of maintaining a routine data collection system, and unless the current information crisis is to be repeated the next time these block grants come up for reauthorization, this Committee must take some definitive, preventive action. Therefore, the ASTHO urges you to consider setting aside one-half of one percent of the S.2301 block grant appropriation to get the states' voluntary, cooperative system back on solid footing.

The CHAIRMAN. Thank you, Mr. Tierney.

Mr. Fogel, critics of the block grants have suggested there is insufficient data to determine if they are meeting State health needs, the various State health needs. However, your testimony seems to indicate that States are, in fact, establishing reporting requirements, collecting data, and auditing funds.

Now, will this information be sufficient to assess trends in relevant health statistics, and are States submitting the required reports in a timely manner?

Mr. FOGEL. Senator, the States are doing what is consistent with the act. The Secretary of HHS has discretion to prescribe the data elements that the States collect. HHS at this point in time has not prescribed specific data requirements but has let the States submit the data that they think is useful, and then HHS will compile the data in an annual report.

I think after that report is compiled, the Congress will have a much better basis for deciding whether the data that you are getting is sufficient for your needs.

I would like to point out it has been difficult in the past from our perspective to evaluate the effectiveness of these programs and to get good data at the local level. And that was true under the categorical programs, and it is true now under the block grant program.

I think that it will be difficult under the block grant program for the Congress to compare data across States and among the States unless we get some consistency. There are certainly voluntary, cooperative efforts among the States to try to get this data, but as of right now it would be difficult to assure that we have a good data base to compare results across States.

Mr. TIERNEY. May I comment on that, Senator?

The CHAIRMAN. You bet.

Mr. TIERNEY. The Association of State and Territorial Health Officials for over 10 years now has been operating the National Public Health Program Reporting System. And it is a voluntary system which involves the 50 States and the territories. It is voluntary. The data is provided by State health departments. It's comparable, and it has a long history of being around.

It is the only data system that we can put together to show what public health departments do on a uniform basis. And in my testimony—I didn't present it orally—but in my written testimony was a request for support for that data base.

The CHAIRMAN. Right.

Now, Mr. Fogel, your report indicates that almost all States view the block grant as the more desirable way to fund preventive health services than the categorical approach, but that about half of the interest groups polled viewed the block grant as the less desirable funding approach.

Now, does your study give any idea of why these perceptions differ so markedly on these two points?

Mr. FOGEL. Yes; it does, Mr. Chairman. I would like to let Mr. Gadsby respond to that because we have done some detailed analyses to try to answer that question.

The CHAIRMAN. All right.

Mr. GADSBY. We are in the process of doing some statistical analysis, and the preliminary results suggest there is, as one would expect, a strong correlation between interest group respondents who were dissatisfied with the block grant as a funding mechanism and those that believe that the people or organizations they represented, had been adversely affected by the funding decisions that States have made.

There was also some indication that the dissatisfied respondents were really not active participants in the citizen input process, and that they tended to be dissatisfied with the State's response to the things that they had raised concern about during the citizen input process.

Mr. FOGEL. But basically, what it boiled down to—and it's not surprising—is those interest groups whose constituents were negatively affected at the local level as a result of this block grant process weren't as satisfied with the process, which is what we would expect would occur.

The CHAIRMAN. Although you did not discover any significant cost savings associated with the management of the preventive health services block grant during the time of your study, do you think that this reflects additional costs related to program transition period? Do you feel that future management may be more economical, or do you just feel that it's going to be kind of a wash?

Mr. FOGEL. We found that it's difficult to really tie a dollar amount to the amount of funds that can be saved in going from a categorical to a block grant. The problem is that there is no baseline and there was no comparable data among the States as to what administrative costs were.

On the other hand, as I alluded to in my testimony, the overwhelming majority of the State officials that we gathered the evidence from felt that the block grant process has streamlined some aspects of their administrative operations. It has made the whole grant application process simpler. They have been able to in some cases reallocate staff to more programmatic missions rather than some of the administrative missions. So in that sense, we definitely think there has been a benefit, but we would be very hesitant to try to put a dollar amount on it, and we think it's going to be difficult in the future.

The CHAIRMAN. You have indicated that most of the States have gone beyond the required legislative hearings and that they have held further executive hearings and they have used advisory boards to determine how to use the funds. Do you think the public—that is, the average citizen—has been given more access to the decisionmaking process, or less, than under the previous categorical programs?

Mr. FOGEL. At this point in time that the block grant process has allowed more people the opportunity to provide input at the State level on how the State is going to spend its funds than the categorical programs did.

In the preventive health block grant, for example, 10 States held executive hearings, and none did when they had categorical funds. And under ADAMH, 13 States held executive branch hearings trying to decide how they would spend this money, where previously only three did. So at the State level there has definitely been more input.

Mr. Gadsby may want to add something.

Mr. **Gadsby**. As Mr. Fogel said, there has been clearly greater opportunities for citizen input. We also tried to get a sense of whether or not private citizens had actually participated in the process, and we found they had, to some extent. They didn't participate much in the mandated process of commenting on the intended-use reports that the States are required to put together. Service providers tended to be the most dominant participants there.

On advisory committees that States had established, private citizens were among the groups most often represented on those committees, and those committees tended to be very influential in the decisionmaking process in the 13 States.

In terms of the executive hearings, we found that some private citizens did participate in those hearings in all the States we visited, but again that service providers tended to be the dominant participants in process.

The **Chairman**. I was somewhat surprised to learn from your testimony that Federal funds constitute only one-third of the financing for preventive health services in some of the States. Could you describe where the balance of the funds really come from?

Mr. **Fogel**. The balance of the funds came from State revenues. But I would like to let Mr. Dodaro answer that in more detail.

The **Chairman**. Go ahead, sir.

Mr. **Dodaro**. Senator, as Mr. Tierney indicated for Rhode Island, many of the States contribute money from their own revenues to help fund these services. Typically, Federal preventive health funds are channeled into services such as tuberculosis control and immunization that are basically provided through State public health laboratories or local health departments. And States naturally channel a lot of their own moneys into those entities as well.

Additionally, some of the preventive health services at the State level are given high priority. For example, in the State of Washington the Emergency Medical Services Program has been a high priority, and the State provides a lot of its own funds for that activity. Also, the State of Pennsylvania has a State mandated emergency medical services act, so by State law the State has to contribute to provide those services.

The **Chairman**. OK. And States that increase their funding of preventive programs following the block grant, did GAO look at the source or rationale for that particular increase?

Mr. **Fogel**. We didn't have much information on that at all, Mr. Hatch. The one point I would like to make there is, that in the Preventive Health Program historically the States have been committed to a lot of these programs. And this is some speculation on my part, but I think from the information we've gathered, that they have just been historically committed to these types of programs and they wanted to maintain these programs in many instances regardless of whether it would be State or Federal funds.

The **Chairman**. OK. Let me just turn to the alcohol, drug abuse and mental health block grant, and I will only ask you one question and then I want to turn to Mr. Tierney and allow time for my colleagues. But I will submit further questions to you on this, and I hope you will get your answers back as soon as possible.

Let me just ask you this one question: What feedback did you get from local and State officials about their new involvement in administering the alcohol, drug abuse and mental health block grant? Has the feedback generally been favorable or negative?

Mr. FOGEL. It's been favorable. Basically, seven States specifically said they were able to reduce their time and effort in preparing applications and reporting on the grant; five said they were able to standardize procedures; and eight said it improved their planning and budgeting process for programs. So I think we would say overall the reaction from the State officials that we talked to was definitely favorable.

The CHAIRMAN. OK. I will submit the remaining questions to you.

Mr. Tierney, we appreciate your being here, and thank you for your testimony.

As you stated, the block grant approach has given the States more flexibility. Now, how has Rhode Island specifically used this new flexibility? Have previously mandated Federal programs been terminated, or how have you handled it?

Mr. TIERNEY. No. Under the categorical system, Senator, we got a piece of money for heart disease and cancer and chronic illness, and we had to stay within those categories and we had to report and make financial statements on them and we had to make program reports. And we had a whole bureaucracy to deal with.

Our approach in Rhode Island in health promotion is to try to deal with health, and there is no categorical grant for health and there's not one for wellness. Now, this Wellness Check Program I described to you initially deals with all those areas, and you could just think of the turmoil you could get. We get a questionnaire with 50 questions. Maybe five are on cancer, so many are on heart disease, so many are on immunization, and so forth. And you imagine the free-for-all we would get into with the Feds if we charged for cancer and this is the heart and this is for this program. And if it gets worse, where would you charge fitness to, where would you charge smoking? Would you charge it to cancer or would you charge it to heart?

We have in the educational programs for children, we try to teach the children how to deal with strangers, and there's no categorical grant for that.

So we have this flexibility. I don't think with categorical grants, that we could have got up the children's programs or the adults' health risk assessment, because we dealt with the general category of health.

We did lose money in the tradeoff, as has been pointed out, but we certainly enjoy the freedom and we can program much better and easier.

The CHAIRMAN. I see. You have commented on the need for funds to facilitate a voluntary cooperative reporting system. Could you tell us why you feel this is important and how the information will be used?

Mr. TIERNEY. Yes. The association—I personally think it's very important. We believe we should be accountable to somebody for the money that is given to us. And we're not unselfish about it either; we want to get some more. But we think there should be a national voluntary uniform system that can be compared among States and that we can report to the Congress and to the people of this country what we're doing with their money and show changes in health.

We would like to implement the national objectives for the Nation that have been published. And we need some kind of a data system in order to do that. We think the one that's up, the one that's voluntary—and we've had 10 years' experience with it—should be the one that should be maintained.

The CHAIRMAN. I was interested personally in your comments about the home health service part of the block grant. If this bill becomes enacted into law, how would Rhode Island utilize its share of the allocated funds?

Mr. TIERNEY. Rhode Island has a pretty good system of home health services. Again, it's a function of size. We're only 1,050 square miles, so we're not too big.

When medicare came in in 1965, we had 27 so-called home health agency, or visiting nurse agencies. Through funds from the department and through grant funds, we were able to bring those 27 visiting nurse down to nine good, solid, strong voluntary home health agencies.

So we have coverage throughout the State. When somebody is home—and I don't have to tell you, you know —but the most important thing to have in home care is first the home. You have got to have a place to be. And the second thing, you've got to have somebody to take care of you, somebody to assume that responsibility. And from personal experience, I know of that responsibility. And we keep thinking of directing all the services to the patient, and currently we think of medical services. Well, the patients needs some medical services, but the thing that makes the difference in them staying home is social services, or the support services. But we place, I believe, too much emphasis on the services to the patient, and we ought to put more emphasis on the services to the person who assumes that responsibility so that they don't fall apart.

So we would strengthen more services in home health, and we would add more, because you have got to have an array of services. Home health won't do it by itself. We have got to have respite services. We've got to have day care services, hospice services, and all those other kinds of service, so we have some choices.

But again, we strongly believe that they should be directed for the patient, of course, but for the one who is responsible.

The CHAIRMAN. Do you support the TB program as a categorical program? And if so, why do you feel it is important that the TB program remain as a categorical program?

Mr. TIERNEY. Yes. Well, the TB program was a categorical program. While the philosophy of the Association of State and Territorial Health Officials is to move to the block grant because of the flexibility, this is a reauthorization, and we don't have any trouble with carrying that forward. I think, to be honest about it, we'd take the money in any form you gave it to us. [Laughter.]

We would prefer a block grant.

The CHAIRMAN. Well, I understand your position.

Without objection, we will put the statement of Senator Charles Grassley into the record in the opening statement part of this proceeding, and mention that he was here but he needed to go to another committee hearing at the Finance Committee. He certainly takes a great interest in this.

Let's turn to Senator Kennedy.

Senator KENNEDY. Mr. Chairman, I understand that our colleague from West Virginia, Senator Randolph, has an extremely pressing engagement, and I would be glad to yield to Senator Randolph.

The CHAIRMAN. That would be fine.

Senator Randolph.

Senator RANDOLPH. Mr. Chairman, I am pleased to be here this morning with you and Senator Kennedy, for the second day of hearings in which members of the Committee on Labor and Human Resources will be receiving testimony on five major Public Health Services Act Reauthorizations. I take this opportunity to welcome our distinguished panel of witnesses who we will talk with today, and I would like to introduce one of those witnesses at this time, Mrs. Martha Chapman, the executive director of the Tug River Community Health Center in Gary, WV, serving the residents of McDowell County, Mrs. Chapman is testifying on behalf of the National Association of Community Health Centers. We are truly pleased to have you with us today.

Three years ago, with the enactment of Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, 21 public health programs that had previously been authorized categorically, were consolidated into four health block grants: The Preventive Health Services; the Alcohol and Drug Abuse and Mental Health Services; the Maternal and Child Health; and the Primary Care Block Grants.

Today we will focus on the Preventive Health Services and the Primary Care Block Grants, as well as the reauthorization of the National Health Service Corps. We will hear testimony as to the status of these vital programs and we will carefully examine the effects that the major changes made in 1981 have had on the individual programs contained these block grants to the States.

I am anxious to hear your knowledgeable opinions on the effectiveness of the Prevention Block Grant as it has provided funding for such important programs as rodent control, fluoridation, hypertension control, home health care, health education/risk reduction, rape crisis centers, 314(d) health incentive grants, and emergency medical services.

Additionally, I express my sincere appreciation to the chairman for his understanding and acceptance of my amendment to provide pediatric emergency medical service projects.

I am also very interested in receiving your funding recommendations for these programs. Although the President's fiscal year 1985 budget proposal has recommended a 2-percent increase for health block grants, I am concerned that this funding level, although reflecting a slight increase over fiscal year 1984 levels, would result in a reduction of services, due to rising medical costs. Based on projections of the Congressional Budget Office, it has been estimated that at least a 6.5-percent funding increase would be needed in fiscal year 1985 for the Block Grant Programs to continue with the same service offerings as in fiscal year 1984.

With regard to the National Health Service Corps, which is so very important to the rural, medically underserved areas in West Virginia, I want to know how the limited numbers of new scholarships awarded in the past 3 years, and how the administration's recommendation that no new scholarships be awarded in fiscal year 1985, has and will affect the availability of health care in health manpower shortage areas.

I am deeply troubled over the reduction in the National Health Service Corps Program, based on the premise that we will be experiencing a physician glut in the near future. Although some areas of our Nation might have an over abundance of doctors, economically depressed and remote rural areas will continue to have difficulty in attracting and retaining health care professionals, thus maintaining manpower shortages. Further, we must look into and address certain problems that have been reported as a result of increased private practice option placements, insuring that the truly needy are continuing to be served.

Last, but certainly not least, we will listen carefully today, to the testimony of those expounding on the Primary Care Block Grant. As I mentioned before, we have the privilege of hearing from Mrs. Martha Chapman. Not only is Mrs. Chapman the executive director of a Community Health Center, but she, along with the directors of the other 18 community health centers in West Virginia, have had the unique experience of operating under the Primary Care Block Grant. An additional problem that Mrs. Chapman's center has had to face it a tragically high unemployment rate in her service area, as McDowell County whose residents the Tug River Clinic services, has an unemployment rate of nearly 25 percent, and in the past 2 years this figure has climbed as high as 43 percent.

The Community Health Centers Program, as authorized under section 330 of the Public Health Services Act, provides support for health services in low-income urban and rural communities which have been designated as medically underserved areas. With the basic purpose of the program being to provide persons in such areas with comprehensive health services, regardless of their ability to pay, our health centers through the primary care program authorities have proven to be effective providers of quality health care to millions of Americans, who otherwise would have no other available source of care. For this reason, and because the Community Health Centers Program is national in scope, serving every State, it is extremely important that we move with caution, when determining how to administer this program.

The Primary Care Block Grant Program established in 1981 is unusual as it covers only one program, the Community Health Centers Program—and participation by the States is purely voluntary, with HHS operating the categorical CHA program in nonparticipating States.

Only one State, West Virginia, opted to receive a Primary Care Block Grant allotment.

Since its original decision to participate in the Block Grant Program, the West Virginia Department of Health has recently determined that it would be in the best interest of the Community Health Centers Program to turn back the block, and return to the categorical program.

This should in no way reflect on our State's Department of Health, as our West Virginia health officials are among the most capable and progressive leaders in the field of public health in the Nation. However, it is my strong opinion that what happened in West Virginia should be studied carefully, and the feasibility of a Primary Care Block Grant Program, as opposed to the categorical Community Health Centers Program, should be reassessed.

Dr. Clark Hansbarger, director of the West Virginia Department of Health has assured me of his desire to be of assistance in determining the most beneficial legislative route to take, whether it be through perfecting the Block Grant approach, or through recategorization, in order that we may protect and enhance our Community Health Centers Program.

I commend all of our West Virginia centers, as they have served so many, so well—particularly when up against the problems that the high unemployment that has plagued our State has caused.

It is my hope that through this hearing, we can determine what we did right in 1981, and recognize what we did wrong—correcting and learning from our mistakes—and building on our accomplishments.

Thank you Mr. Chairman.

The **CHAIRMAN**. Thank you, Senator. Nice to have you here.

Senator Kennedy.

Senator **KENNEDY**. Thank you very much, Mr. Chairman.

I would like to extend a warm welcome to our panelists here this morning, and to our other witnesses that will be appearing after them on these very important health issues of preventive health care, disease prevention, health promotion, community health centers. Preventive health care is our most cost-effective form of health care. It is also our most humanly effective, because it allows individuals to avoid the pain and suffering that disease brings. Community health centers are of vital importance in providing quality care to many of those who have been left out of the health care system, or would be left out, these centers are facing increased demand as a result of economic conditions which have seen more and more people either lose their jobs or move into the area of poverty.

We are struck by the recent census figures of some 8 million more Americans below the line of poverty. And we have also seen the fact that as there have been additional cutbacks in support for many of these programs, many individuals who have health needs in our society are actually kept out of the whole health care system.

And we are mindful of the importance of the National Health Service Corps and the role that it has played in meeting these vital needs, as well as the attempts to eliminate that program and the fact that it has been able to endure in spite of the assaults on it by the Administration.

So I just want to welcome all of our witnesses here today. I would like to have the statements that refer to these three areas of health policy included in the record as if read, if there is no objection to that, Mr. Chairman.

The Chairman. No objection.

Senator Kennedy. What I would be interested in hearing from this panel is on the issue of the criteria, how we really find out what is working and what is not working in our States with regard to health promotion and disease prevention.

As was mentioned by Mr. Tierney, we have the Surgeon General's report of 1980 on promoting health and preventing disease. It establishes these 226 measurable preventive objectives for 15 priority areas. And then we heard Mr. Fogel and, I believe, others talk about the fact that we have in the block grant program the States moving into different areas of need. Resources in this area of health policy have an enormously significant impact in terms of the well-being of the individual and in conserving scarce resources, whether it is individual resources or community resources or Federal resources.

But I am interested in trying to see as we support these programs and as we go back to the American people to ask for additional help and support for these programs, what actually is working and how effectively these programs are working.

We have, as I mentioned, in the Surgeon General's report, after a very considerable degree of study and review, some very clear criteria about steps that can and should be followed. It seems to me it would be useful and wise for us to at least ensure, as we are expending these resources, that we are going to be able to measure the achievement in the States over any period of time.

The concern that I have about the block grant program is that we have not been sufficiently specific with regard to standards and priorities and accountability or measurement or a clear relationship to either the national or local objectives.

I am just wondering, given what Mr. Tierney has said about the past about the paperwork that is included in various categorical programs, whether he would not feel that it might be useful and helpful to us as we are supporting these programs, to have at least some criteria so that we know what is happening in the States, we are able to compare the successes and the failures in other States and we know what is having the greatest impact in the whole range of preventive health care and whether it wouldn't be more efficient and effective and wiser a way of proceeding?

Mr. Tierney?

Mr. Tierney. Well, I can speak, I guess, for Rhode Island. We have this health risk assessment instrument that we have given to 30,000 Rhode Islanders. Now, the program is only 3 years old, and that is exactly what we are trying to measure. Not that the sample of the people that come on the Wellness Wagon are truly representative of all the people of Rhode Island, but it's not bad. And the statisticians would ask for a lot of t-tests or the chi-square. That's not my business. Our business is to get the message out, and I think we're doing that.

We are seeing changes. We are seeing reduced smoking. We're seeing more use of seatbelts. We're seeing changes in food habits, and we're seeing these things.

One of the things that drives me on is, before the Surgeon General's report in 1964, we surveyed Rhode Island's physicians so we could get a fix on their smoking habits before the word came out from the Surgeon General. And we found out in 1963—we did it in the fall; as you remember, the Surgeon General's report came out in January 1964—in the fall we surveyed all the licensed physicians of Rhode Island. We found that one-third of them smoked cigarettes, one-third of them never smoked, and one-third of them smoked and quit.

And we have tracked them every 5 years: 1968, 1973, 1978, and we did 1983 this past fall. Every year, the physicians are down. As a matter of fact, they went from 33 percent in 1963 to less than 8 percent in 1980.

So I believe you can change that behavior. They did it. They know more than anybody else about the impact on health.

The objective for the Nation is to move this country to 25 percent smokers by 1990. Currently, 33 percent of the people smoke. So the people are now where the doctors were 20 years ago, in 1963. One-third of them smoke cigarettes. And I really believe we can move it.

And the data that we have—and again, it's short, and it may be biased, only 30,000—show it's dropping about 1 percent per year.

Mr. FOGEL. Senator Kennedy, let me respond to that from the General Accounting Office perspective. Obviously, our job is made easier in terms of finding out what's going on and preparing reports on programs across the States, if the Congress, or the executive branch, is clear in terms of the type of data that they would like to see gathered for comparison purposes.

I remarked earlier that the Secretary does have discretion under the current act to prescribe data needs. Now, the administration has not seen fit to do that up to this point in time. As we understand it, what they want to do, is to see what the States come in with. This will make it, more difficult from a methodological and a measurement standpoint to provide good, comparable information across the States. And indeed, if it's the concern of the Congress to know what's going on; it would be beneficial to have some consensus on what it is we're trying to achieve at the local level with the delivery of services.

Senator KENNEDY. Well, it seems to me that we hear a great deal of rhetoric around here that the Congress "throws money at problems and money doesn't resolve them." But we also hear that we ought to have a degree of accountability so that we know whether programs are effective or whether they're working.

And the Surgeon General's report of 1980 I think has outlined some very important goals and recommendations which I would think would be sufficiently flexible to permit the States to develop plans within those criteria and still permit the cross-referencing of the material to know whether these programs are actually working and working effectively.

There are various goals with regard to infants and infant mortality and low birthweight and birth defects and about healthy children, and a great variety also with regard to adults and older adults.

It seems to me that it would be of value and use, if we are going to be trying to get the support for this program, to be able to go back to the Congress and say, "Look, these are the results of the program, allocation of resource, and what's been done with regard to either the health of children or infant mortality or low birthweight, or with regard to the health conditions of our senior citizens, whether it's in the area of home health care or other areas.

Do you have any objection to having that kind of accountability?

Mr. TIERNEY. Absolutely not. The Association of State and Territorial Health Officials has a national public health program reporting system that has been up for about 12 years. It's voluntary. It's uniform. You can compare 50 States and the territories in their activities. And this could easily be adapted to report many of the things in which we are attaining the goals as enunciated by the Surgeon General throughout the country?

Senator KENNEDY. What about the rest of the panel?

Mr. FOGEL. Well, I think from the GAO perspective, we would view that as basically a policy decision for the Congress regarding how it wants to get information on what's happening out there. But, we're basically concerned that we do obtain information.

Senator KENNEDY. Just in terms of carrying on your own responsibility in doing evaluation, would it be easier or more difficult if you had that kind of thing?

Mr. FOGEL. Oh, it would definitely be easier for us to undertake an assessment.

Senator KENNEDY. Would it be easier to find out what's working and what isn't working, what's effective, what's not effective?

Mr. FOGEL. Yes; it would be.

Senator KENNEDY. How much of a burden would this be in terms of the States, do you think, in developing these kinds of plans?

Mr. TIERNEY. I think the States would be very interested in this. As I said, they've been participating in the national public health program reporting since for a dozen years. We want to be accountable to the Congress, and we want to demonstrate that the money that has been given to us we have used wisely and we are, in fact, making a difference. And we welcome a reporting system.

As I say, we've got one up, and we ask that consideration be given that one-half of 1 percent of the appropriation be used to finance the existing reporting system, which can be modified to meet the needs that you described.

Senator KENNEDY. Let me ask you, what has been the effect of the total moneys that have been available to the States for preventive health in the period of the last year? What has been the impact?

Mr. FOGEL. We have some information on that, Senator, from the 13 States we have looked at, not though, in terms of effect on the actual delivery of services and changes in people's health condition. The objective of our work first was to find out literally what was happening in terms of the process.

The interesting thing in the preventive health areas is that Federal funds decreased, about 12 percent in the first year and then they went back up again. But overall—and Mr. Dodaro has some more statistics on that—most of the States ended up funding their preventive health programs at an increased level even though Federal funds went down, because of State contributions.

But there is one other important thing to remember in both the preventive health and in the alcohol and drug abuse and mental health block grants. We think one of the reasons we have not seen too much of an effect yet is that the States were able to carry over a lot of their categorical funding from 1981 to 1982; therefore, they were able to carry over block grant funding. For example, they were able to then use block grant funds which they got in 1982 in 1983.

So we have not really seen the effect yet from funding changes.

Mr. DODARO. That's true, Senator. Many of the awards made under the categorical programs in 1981 extended into 1982. This permitted the States to have available categorical funding at the same time as the block grants were implemented. So there was actually a period of overlapping funding.

Senate KENNEDY. Well, what happens now? What will be the——

Mr. DODARO. Generally, what we have seen, Senator, as the categorical money is being dissipated over time, the Federal share of total program financing in the States is declining and that States revenues are taking on an increasing proportion of total program costs. This is true both in the preventive health block grant and the Alcohol, Drug Abuse and Mental Health Program, and several other block grants that we are looking at.

So several States are attempting to help offset Federal reductions. In other States, State funds have declined, and we have seen a greater drop in total program financing during the period.

Additionally, once inflation is taken into consideration, in the preventive health block grant only 3 of the 13 States over the 1981 to 1983 period actually increased expenditures in real terms, considering funding from all sources—Federal, State, and local.

Senator KENNEDY. Three out of?

Mr. DODARO. Three out of 13.

Senator KENNEDY. Well, what happened to the other States?

Mr. DODARO. The other States' funding, total program support, in real terms declined.

Senator KENNEDY. So as a general matter, there has been a general decline over the country?

Mr. DODARO. Once inflation is taken into account, yes, that's right.

Senator KENNEDY. Well, that is the reality of today.

And what do you anticipate in the next year? Of course, it depends on this current fiscal year in terms of the 1984 level.

Mr. DODARO. Well, a lot of it obviously depends on the Federal appropriations as well as State revenues. But during the 1981 to 1983 period some of the States had to make decisions on which program areas within the block grants would continue to receive priority over other areas. And they have been making those decisions in terms of tradeoffs as to which program areas to maintain and which to reduce.

What we seen in the preventive health area is that the hypertension area, health incentives area, fluoridation, and health education and risk reduction expenditures have been generally maintained, while those that have been dedicated to emergency medical services and urban rat control activities generally speaking in some of the States have declined during that period.

So the States, in fact, are making decisions and setting priorities as opposed to across-the-board reductions in programs.

Mr. FOGEL. If I can generalize, I think that what we will see in the next several years is that—and this is consistent with the intent of the legislation—the States will be getting a certain sum of money, and they are going to have to make some decisions on how they want to allocate the resources.

If we can use the past as a prologue, what we notice in the health area is the States have tended to put their own funds into programs that they historically—and this goes back over a number of years, 20 to 30 years, 40 years, in some cases—have been involved with. And from our perspective we think the next several years will really give us more of an indication of how the States can make decisions with block grant funds than the first several years did, because of the carryover of some of the categorical programs.

Senator KENNEDY. I would be interested whether you thought some kind of a systematic planning approach with higher funding would move us toward the goals of better health care?

Mr. FOGEL. Well, let me give a Federal perspective, and then I would be interested in what Mr. Tierney says of this, too.

I guess from our perspective, when we looked at how the block grants were working, one of the encouraging things we found was that the States were able to integrate decisions on these moneys into the basic program and policy decisions they were making in their States regarding how they wanted to spend their total health dollars. We found that the overwhelming majority of State officials, both executive branch and legislative officials, that we talked to felt that was an improvement. The Governors were more involved in the decisions, and the State legislatures were also more involved. And indeed, even interest groups were involved in inputting into substantive decisions on how the States were spending their money.

In the broad preventive health area 97 percent of the money was State money anyway, so the marginal change you could get with Federal dollars is fairly narrow. To the extent the States had fairly good planning and decisionmaking processes for their health programs, they should have been able to intergrate this money in those processes. Now, to the extent they didn't have good planning processes that's something I think the States would just have to deal with. But we found overall that because this money was more integrated into their normal decisionmaking process, they felt better about the decisions they were making.

Mr. TIERNEY. That's true. We would underline that. We have a State health plan, and we've set up five priorities these next 3 years that we're going to implement. One of them is health education, life-style health promotion. We set our own goals and objectives.

We did get this so-called "carry forward" money. We got money both in the block and the category. Somebody was sleeping, I guess. Anyway, but that's going to run out.

States are in trouble, Senator. We've got a 5.5 percent cap on the budget in the State of Rhode Island. The expenses are going up better than that. The carry forward money has been helping us along, and we're going to face reality starting July 1, 1984. And I would guess that our efforts may taper off. We're trying to prevent that. Medicaid is killing us, as a State, not a health department. And we're going to try to get some new initiative. Our biggest initiative now is injury control, and we put bills before the legislature to have a statewide 911 number, establish a division of injury control in the Department of Health, and also to make moneys available to supplement the EMS section of the block grant.

Senator KENNEDY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Pell.

Senator PELL. Thank you, Mr. Chairman.

First I wanted just to belatedly welcome John Tierney, whom I have known and admired for many years from my own State of Rhode Island. And second, to express my own thought that as a general rule I am inclined to the categorical side of funding because I think that more clearly preserves the intent of Congress.

What worries me very often in the block approach is the original intent of Congress can be muffled as the 15 agencies of a State vie for the funds. And that philosophical point I think we sometimes lose sight of.

Third, in connection with the wellness program, I would like to commend the game, Mr. Tierney. I have been through that checklist myself and was much impressed with the job it did. And I remember being very impressed with the council on wellness that Governor Jerry Brown set up in California some time back. I am sure it has probably been dissolved or scattered to the winds by the present California administration. But I would hope that other States might emulate it.

I thank you for this opportunity to say a word. Thank you.

The CHAIRMAN. Well, thank you, Senator Pell.

We want to thank each of you for appearing here today, and we appreciate you, Mr. Tierney, for coming down from Rhode Island. We are glad to have you here, and thanks for being with us.

Mr. TIERNEY. Thank you.

The CHAIRMAN. Our second panel is composed of three distinguished members who will address S. 2308, the Primary Health Care Amendments of 1984, and S. 2281, the National Health Service Corps Amendments of 1984.

Our first witness will be Ms. Jean Chabut, chief of the Health Promotion and Disease Prevention Administration of the Michigan State Department of Health.

Next will be Mr. Stephen Wilhide, executive director of the Southern Ohio Health Services Network. He will be representing the National Rural Primary Care Association.

Following Mr. Wilhide is Martha Chapman, executive director for the Tug River Community Health Center of West Virginia. She will be representing the National Association of Community Health Centers.

So we want to thank all of you for taking time from your busy schedules to testify before the committee today.

Ms. Chabut, we will begin with you, and we will take your testimony at this time.

STATEMENT OF JEAN CHABUT, CHIEF OF HEALTH PROMOTION AND DISEASE PREVENTION ADMINISTRATION, MICHIGAN STATE DEPARTMENT OF HEALTH, ACCOMPANIED BY STEPHEN WILHIDE, BOARD MEMBER, NATIONAL RURAL PRIMARY CARE ASSOCIATION, AND EXECUTIVE DIRECTOR, SOUTHERN OHIO HEALTH SERVICES NETWORK; AND MARTHA CHAPMAN, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC., AND EXECUTIVE DIRECTOR, TUG RIVER COMMUNITY HEALTH CENTER

Ms. CHABUT. Thank you very much, Mr. Chairman. Please accept my gratitude for this opportunity, and my thanks for the important leadership that you are providing on this issue.

I would like to comment first about the National Health Service Corps and S. 2281. The National Health Service Corps program has been extremely helpful in assisting Michigan to deal with problems of physician and other health professional maldistribution. I think we hear a great deal these days about the various diffusion theories which conclude that our maldistribution problems may soon be solved as a result of the current oversupply of physicians. We in Michigan are experiencing an increase in physician supply, but our own data on where these physicians are locating make it clear to us that the problems of distribution will not be solved by diffusion alone. We will continue to need the National Health Service Corps, and we are very pleased to see the Senate express a long-term commitment to the program through S. 2281 and your remarks in introducing this bill.

As we come to grips with the changing medical marketplace, old strategies that worked effectively in the past few decades may need to be reshaped some in order to take into account the changes that will be produced in the marketplace by new health care financing policies and reductions in medical school enrollments.

State contract demonstrations have been an important first step in establishing a means of collaboration between the State and Federal Government in resolving manpower issues. We are one of 28 States with a contract to participate in the National Health Service Corps placement program. As a result of the contract, States have become involved to a greater degree in determining priority areas for placement and in facilitating the recruitment and match process, as well as management of assignees in the field.

The contract provides flexibility with respect to the degree of responsibility States assume in concert with their interests and capabilities.

We commend HHS for developing the State demonstrations, and we are pleased to see a recognition for the need to engage in a State-Federal partnership in manpower planning that S. 2281 will stimulate by including Governors' involvement in the Secretary's plan for 1988 and beyond.

S. 2308, dealing with the primary care block grant, and the vital services of community health centers is also an extremely important proposal. The thrust of this legislation is to bring about a more effective State-Federal partnership in the delivery of primary health care. We support this thrust and believe it can benefit the community health center program. This program has a tradition of excellence and provides cost-effective primary health care to people who would otherwise fall through the cracks of our traditional health care system.

It deserves our full support and has to be nourished in every possible way. Michigan has had a long history of involvement in primary health care, and we have been pleased to work with our federally funded community health centers in our State. We have learned a great deal from this relationship and are committed to its continued growth.

To further strengthen this relationship, we have occasionally considered applying for the primary care block grant. We have been unable, however, to bear the financial and other burdens required by the current block grant legislation. The disincentive has been too strong. S. 2308 addresses many of these disincentives and has, we think, the potential of generating closer partnerships between several States and the Federal Government.

There are two principal policy issues addressed by this legislative proposal. Perhaps the most important issue relates to the money and matching fund requirements. Direct Federal funding of community health centers does not require matching funds. However, to be eligible for the block grants, States must now provide a 33 percent match and assure ongoing financial maintenance of effort regardless of Federal appropriations levels. This has effectively prevented States from seeking the block grants.

S. 2308 requires a 10 percent match. We support this. A 10 percent match requirement will require States which are serious about primary care to apply for the block grant. It should effectively discourage those States who are unwilling to make the financial commitment to primary care. It would permit Michigan to seriously explore with our community health center leadership the possibility of our applying for the block grant.

S. 2308 quite appropriately requires at least 1 year of continued funding for previously funded community health centers. This will assure continuity and permit subsequent Federal appropriations to be considered in making ongoing funding decisions.

The second major issue is the designation of medically underserved areas which are eligible to receive funds for primary care. A stronger role for the States in making these designations is badly needed. Obviously, a national standard is required in order to maintain congressional intent. The States, however, are quite familiar with community conditions and are often in a better position to identify and enforce specific criteria which are the strongest indicators of a medically underserved area. In the cases of States which ultimately would elect to assume the block grant, we would suggest that the States, in consultation with their community health centers, develop designation criterion consistent with standards established by the Federal Government. In other cases, a closer consultation with the States would be helpful.

In all cases, we would suggest a formal appeal procedure which can consider unusual local circumstances in the designation process. S. 2308 moves in this direction, and we hope these suggested refinements can be considered as the committee deliberates its final decisions.

Mr. Chairman, we are pleased to see that the authorized funding levels proposed by S. 2308 recognize the need to maintain a significant portion of the funds which were added to this program in fiscal year 1983 and which will be partially continued in 1984. In fact, the proposed authorization would permit a 2.5 percent increase between fiscal year 1984 and 1985.

It is important, however, to recognize that this program was reduced by nearly $30 million between 1983 and 1984. There was an even larger reduction of $57 million between 1981 and 1982. The proposed authorization would barely return the program to its fiscal year 1981 level of funding.

We urge the committee to seriously consider the need for a somewhat higher authorization. The impact of inflation since 1981 needs to be recognized. We believe that our recent recession has increased the need for primary health care in our medically underserved areas. In the long run, these services are investments which help avoid the higher costs that are predictable if these health care needs are neglected.

The key policy issue before us is how best to meet the needs of the people in medically underserved areas and what, if any, role a viable block grant program can play in accomplishing this. Perhaps we are not ready for a nationwide community health centers program to be folded into the block grants of the States. Many States are still pondering their role in providing primary care. Others, however, are not ambivalent; they simply have insufficient resources to do what is needed. In these cases, a carefully designed block grant could be productive from all points of view. It can add State resources to Federal leadership and Federal funds. I think it has the potential to strengthen the commitment of State governments to primary care, just as Federal leadership has accomplished this in other health services, including maternal and child health, alcohol and drug abuse, family planning, and many others.

The provisions of Senate bill 2308 are positive steps in the right direction. We hope our suggestions can be considered as you proceed with this important matter. You may depend on our continued advocacy of the community health centers program. Our people benefit greatly from these services, and we are proud to be associated with them and wish to see an even stronger association in the future. And perhaps most importantly, Mr. Chairman, we thank you and this committee for taking such prompt steps to deal with what are difficult issues.

We realize that you are presented with conflicting points of view. We are confident, however, that everyone's attention is focused upon the primary health care needs of our medically underserved population. They deserve our very best effort to shape a public policy which gives them a better chance to obtain the health care which most of us take for granted. We are anxious to help in any possible way. Thank you.

[The prepared statement of Ms. Chabut and responses to questions submitted by Senator Hatch follow:]

STATEMENT OF

MS. JEAN CHABUT
CHIEF
HEALTH PROMOTION AND DISEASE PREVENTION ADMINISTRATION
MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Primary Care Needs in Michigan

Mr. Chairman, thank you for the opportunity to appear before the Labor and Human Resources Committee to provide you with information about primary care needs in Michigan and our perspective on the proposed primary care block grant.

Community Health Centers were established in 1965 through the Office of Economic Opportunity out of recognition that mainstream health care was not responding to the needs of all groups within our society. The Community Health Center legislation was aimed at responding to the problem of access to basic health services created by financial indigency, geographic or cultural barriers and other factors that result in some population groups not getting needed services. Unfortunately, the medically indigent population is growing as a result of the prolonged and high unemployment our region has experienced over the past few years and CHCs are needed more critically than ever.

The CHC program has been uniquely successful in achieving its goal. As state policy makers come to grips with today's major health care issues of cost containment, charcterized by out-of-control Medicaid budgets, they would do well to examine the track record of community health centers for lessons that can be learned in targeting resources effectively. Community Health Centers have been particularly effective in reaching those groups within our society that are most vulnerable to being excluded from care, and exhibiting the worst health status measures. In other words, these persons most likely to cost the health care system the most dollars when their neglected conditions finally result in a medical crisis.

Community Health Centers have been effective in encouraging the use of preventive and health promotion services.[1,2]

Community Health Centers are providing basic ambulatory services in less costly settings than hospital outpatient departments and emergency rooms.[1,3]

Community Health Centers reduce in-patient hospitalization among their users. A factor that is highly significant in controlling the most expensive part of health care.[4,5,6]

CHCs have been energetic and innovative in mobilizing their communities to deal with larger community health problems, such as environmental issues. This in part, is reflective of the community governance principal that has been a major tenet of this program.

In Michigan, the first Community Health Center was established in 1970 through a partnership of the City of Detroit, the State Health Department, and the Governor's Office. This Community Health Center serves a hispanic population in Southwest Detroit. Later federal CHC funding became available and today the center is supported by both federal and state funds Over its 14 year history, the Community Board continues to demonstrate remarkable commitment to a community responsive approach in delivering comprehensive care for the residents of the area. Over the years, the number of Community Health Centers in Michigan has risen to 20, and they are supported by a combination of state and federal funds. We have come to regard these CHCs as an integral part of our public health delivery system, and utilize them to carry out other important public health services such as the Women, Infant and Children Supplemental Nutrition Program, infant mortality initiatives, and health education programs.

I mention this to emphasize the important priority we place upon preserving the essential features that have characterized the CHC Program and contributed to its effectiveness, including the community governance structure. Michigan has had a fourteen year history of managing a small state supported CHC program that is not operating under any federal requirements at all. These state supported CHCs are, however, identical in every way to federally supported centers including their governing structures and their array of services. While we have been managing CHC's for a long time, we have learned a great deal about administering primary care programs through our Memorandum of Agreement (MOA) with the federal government. The agreement allows states to participate in the resource allocation and monitoring process for federal CHCs. As a result of our exposure to federal management systems, we have adopted the federal reporting system for our own state centers. Our process for administering state centers including review of their annual applications, review of their performance and the financial relationship for providing them their funds is very similar to current federal administrative procedures. We find that communications between our CHCs and state administrative staff is more frequent because we are closer to the centers. We are fundamentally convinced that CHCs benefit from this closer relationship because state staff are more familiar with the dynamics of local communities, and better able to help CHCs with their problems. The state also benefits by what it can learn from CHCs, i.e., the CHC Program has important implications for state health care financing policy in this era of health cost containment since it has been able to address the issues of access and prevention in a cost-efficient way.

The primary care block grant created by the Omnibus Reconciliation Act in 1981 provided a first step toward developing a state/federal partnership in conducting the community health center program. Unfortunately, states have been prevented from assuming this block because its provisions are unusually discouraging. Michigan is spending about $1.5M for CHCs but would need to find an additional

$1M to take the block grant. Our state has been in desperate financial shape

shape for the past few years, and in spite of a commitment to primary care, we could not appropriate more money at a time when other state services were being cut.

The federal and state partnership created by the block is important for a variety of reasons. First, it allows state and local government to make a financial investment in Community Health Centers because states are assured of some meaningful role in their administration. Where the federal government has created programming that allows states to participate administratively, states have followed by making significant financial contributions to the program. A 1983 report from the Association of State and Territorial Health Officials describing state health agency spending illustrates this phenomena very well. States contributed 37% of total spending for MCH, 34% for family planning, 45% for genetic diseases, 72% for general communicable disease control, 43% for immunizations, 15% for hypertension and 60% of alcohol and drug abuse. As these figures illustrate, state spending occurs regardless of match requirement. Community Health Centers on the other hand are pretty much reliant on federal funding for their support because their development has essentially by-passed state and local government.

Another reason why states should be involved in Community Health Center programming is because it allows them to do a better overall job of resource management when they are in a position to distribute both state and federal funds. States can plan for a complementary distribution of resources for MCH, chronic disease and primary care to a given area. CHCs will more often than not be the beneficiaries of such planning because states familiar with the cost efficiency and community sensitivity of CHCs will view them as appropriate agencies to carry out other personal health programming.

States are also in a position to help CHCs carry out the difficult job of maintaining a service delivery structure in underserved areas through their regulatory and grant making authorities when states become sufficiently sensitized to the types of problems CHCs encounter. For example, rural clinics often have difficulty keeping their physicians because the physicians come to feel professionally isolated from their peers. Support networks can be helpful in alleviating this problem. In Michigan, we have taken a state supported subsidy program for family practice residencies and restructured it specifically to address the isolation problem for rural CHCs and NHSC sites. This would not have occurred if the state had not learned about the unique problems rural clinics face through exposure to Rural Health Initiatives through the MOA with the federal government.

We support most of the key provisions of Senate Bill 2308 because they correct several of the problems associated with the primary care block. The 10% matching provision is reasonable and appropriate. Since many states have not previously been involved in primary care, some financial commitment demonstrated by the match should serve to reassure CHCs that states are committed to the program.

Many states have developed their capacity to administer various personal health programs as a result of federal initiatives. States were readily able to assume the other health blocks in 1981 because they had in most cases already been administering the categorical programs on behalf of the federal government. State administrative structures were already in place. The Primary Care Block grant should make provisions for states to develop the capacity to administer primary care by providing funds for state administration and for competent long-term planning. We would welcome a strong role by CHCs in policy, administrative, and planning decisions, and perhaps legislative provisions should assure such a rule.

Mr. Chairman, we are pleased to see that the authorized funding levels proposed by Senate Bill 2308 recognize the need to maintain a significant portion of the funds which were added to this program in FY 1983 and partially continued in FY 1984. In fact, the proposed authorization would permit a 2 1/2% increase between FY 84 and FY 85. It is important, however, to recognize that this program was reduced by nearly $30M between 1983 and 1984. There was also a substantial reduction in this program between 1981 and 1982. The proposed authorization would barely return the program to its FY 1981 level of funding.

We urge the committee to seriously consider the need for somewhat higher authorization. The impact of inflation since 1981 should be recognized and we believe that our recent recession has increased the need for primary health care in medically underserved areas. In the long run, these services are investments which help avoid the higher health care costs which are predictable if these needs are neglected.

With respect to the designation process for determining medically underserved areas, we are greatly heartened to see a provision in the bill to give Governors some voice in designation areas within their states.

The updating of the federal Medically Underserved Areas data base may result in as many as five of Michigan's 17 CHCs losing their MUA dsignations and federal funding. This is most unfortunate considering that these same clinics are serving increasing numbers of unemployed, medically indigent and Medicaid. One jeopardized center for example, reports that 25% of its patients have incomes below 200%

poverty, and 31% are on Medicaid. The factors that have resulted in the loss of the designation have to do with the movement of private physicians into the area. It is a shame that the community's investment in a clinic that is clearly providing care to the population Congress intended to be served is in jeopardy of closing because of a loss of the designation. It is evident from this example, that the federal designation process is too insensitive to measure local needs in some instances. For states that assume the block, it is appropriate to allow the state in consultation with their CHCs, to establish more sensitive criteria of need that could be approved by the Secretary and then used in lieu of the federal designation.

Where the state does not assume the block, the closer consultation provided by SB 2308 between states and the Secretary will be a helpful first step in establishing improved criteria. In all cases we would hope a formal appeal process that has the ability to consider appropriate local factors of need could be developed.

I would like to spend a few minutes commenting on the NHSC Program and SB 2281. The NHSC Program has been very helpful in assisting Michigan deal with the problems of physician and other health professions maldistribution. We hear a great deal these days about various diffusion theories which conclude that our maldistribution problems may soon be solved as a result of the current oversupply of physicians. We in Michigan, are experiencing an increase in physician supply, but our own data on where these physicians are locating make clear to us the problems of distribution will not be solved by diffusion alone.

During the period from 1961 to 1980, Michigan gained 6,800 physicians. Most of the increase was concentrated in areas which already had a relatively large supply of physicians. As the table below shows, the counties with the greatest concentration of physicians--those with more than 160 physicians per 100,000 population--increased in number from 4 to 11 between 1961 and 1980. The county with the highest ratio of physicians to population in 1961 had 343 physicians per 100,000 population; that county had 535 by 1980, an increase of 56 percent. In contrast, there was no reduction in the number of counties which had fewer than 72 physicians per 100,000 population. In fact, the number of such counties actually increased by one.

Physicians Per Hundred Thousand Population	Number of Counties	
	1961	1980
Fewer than 50	17	18
50 to 71	18	18
72 to 160	44	36
Over 160	4	11

A major reason for this lack of progress is that five of the _urban_ counties in the state (all but one of which were already well supplied with physicians in 1961) absorbed 70 percent of the increase in physician supply. Oakland County, alone, gained slightly more than one-third of the 6,800 licensed physicians that were added to the state's total supply between 1961 and 1980. During the same two decades, 45 counties gained fewer than 10 physicians apiece, and 8 of these counties actually lost physicians.

We have examined the placement of Family Practice Residents graduating from the state's 22 Family Practice Residency Programs and find a clear difference between the practice locations of those with NHSC obligations and those who can voluntarily practice anywhere. We have summarized the finding in Table I. It is clear that the NHSC is directing physicians to towns of less than 10,000 population and inner city neighborhoods of large cities while residents without obligation tend to select mid-size cities.

TABLE I

Family Practice Residency Graduates	NHSC Obligated Physicians	Community/Town/ City Populations
25%	46%	<10,000
32%	11%	10,000 - 49,999
24%	9%	50,000 - 250,000
13%	34%	>250,000

The NHSC has worked in complementary fashion to the CHC grant program allowing rural and isolated clinics to have a reliable source of qualified personnel.

As we come to grips with the changing medical market place, old strategies that worked effectively for the past few decades may need to be reshaped to take into account change that will be produced in the market place by new health care financing policy and reductions in medical school enrollments.

State contract demonstrations have been an important first step in establishing a means of collaboration between state and federal government in resolving manpower issues. States have become involved to a greater degree in determining priority areas for placement and in facilitating the recruitment and match process, as well as management of assignees in the field. The contracts provide flexibility with respect to the degree of responsibility states assume in concert with their interests and capabilities. We commend HHS for developing the state demonstration.

We are pleased to see a recognition for the need to engage in a state/federal partnership in manpower planning that SB 2381 will stimulate by including Governors involvement in the Secretary's place for 1988 and beyond. We hope this plan will take into account the following recommendations:

1. Include new authority for proposed loan forgiveness program as a mecnanism for recruiting health professionals into the NHSC program to serve in prioritized areas. The loan forgiveness should act in complement with the scholarship and volunteer recruitment program.

2. The Secretary will request from state contracts and/or state and local health planning authorities, projections of future manpower needs. The Secretary will provide support for states to carry out this activity. These state proejctions will be used as the basis for annually determining numbers of: scholarships, recommendations on distribution of scholarships between medical schools and their subsequent distribution for placement, volunteers, federal salaries, loan repayment participants, and start-up loans.

3. Within the level of total scholarships established by state projections, scholarships should be allocated to medical schools based on a combination of factors including:
   a) percent medical school graduates entering family practice residencies;
   b) percent medical school graduates practicing in hard-to-fill states;
   c) percent medical school graduates practicing in HMSA
   d) minority student enrollment
4. Medical school graduates should be provided incentives established by the Secretary to enter into family practice residencies.

5. The Secretary should identify effective training exprelences for preparing NHSC scholarship recipeints to serve in shortage areaws.

6. The Secretary is encouraged to allocate assignees to states who will allocate them to areas of need according to state priorities.

7. The Secretary will develop a plan for the establishment of incentives for NHSC assignees to select "hard-to-fill" states/areas.

In closing, I would like to say, Michigan's long-standing cooperative relationship with HHS estblished through the Primary Care Research and Demonstration and later a Memorandum of Agreement for primary care has been of tremendous benefit in assiting the state develop primary care expertise. We commend the Department for their support and encouragement in helping us become a more effective partner and strongly recommend continuation of MOAs and capacity building demonstrations with state government.

MDPH/DHCS
3/84

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Questions for Testimony

NHSC

1. How have the state demonstrations worked?

    a) Excellent intent in establishing state/federal partnership
    b) Contracts allow flexibility between states with respect to degree of responsibility and interest in various facets of management
    c) Provide states with resources to develop their expertise in solving related manpower problems at the state level
    d) States have the inherent capacity to make more sensitive and less arbitrary decisions than the federal government because they are closer and know the situation better
    e) These advantages must be weighed against the aspects of political liability in areas perceived as undesirable
    f) States can agree to take on this liability when they have some flexibility to make more sensitive and less arbitrary decisions and when they see some agency capacity building going on

2. There has been some indication of a bias against urban areas in placing NHSC assignees. What is your perspective about this?

    a) Michigan has ___% rural and ___% urban HMSAs. We will place for the 1984 cycle ___% assignees in rural areas and ___% in urban areas. We believe placements should reflect the demographic characteristics of each state and this will vary considerably with respect to urban, rural proportions
    b) The concern has arisen as a result of the effort of the NHSC to distribute a fairly limited number of salaried personnel into those areas with the least likely possibility of offering a viable private practice
    c) There has been perhaps an erroneous assumption made that urban areas have more financial resources at their disposal to pay practitioners to serve non-paying patients. However, this is an erroneous assumption. Urban areas have a disproportionate amount of the poverty problem and need relatively greater amounts of resources to cope with their problems. Taking all combined forms of resources. federal grants, state and local government spending in total, there is still a cap in coverage and urban areas suffer from this as well as rural areas
    d) A better solution for the NHSC program would be to distribute allocations of salaries on a state basis as allocations of field personnel are now done. Then states could use the limited salary slots in the most financially hard pressed areas, some of which would be urban and some rural.

3. In what ways do states not have input into the designation process:

   a) With respect to both MUA and HMSA, states now have input in the sense that HSAs initiate designation requests and both HSAs and the state SHPDAs review and comment on the MUA and HMSA lists

   b) The problem arises when gross criterias of measurement necessary for national consistency are applied to very small geographic areas with unique local problems. Neither the HMSA nor the MUA measure problems of access that state government and local communities are in a better position to be aware of. The changes in the Primary Care Block grant legislation requiring the Governor's involvement in the MUA process will be very helpful in solving this problem by allowing an appeal process

Primary Care

1. How will changes in the block grant make conditions better for CHCs?

   a) CHCs will benefit from the involvement of Governors with respect to the designation process. Because of recent increases in physician supply, some centers are in danger of losing their MUA and, therefore, their eligibility for federal funding even though these centers are still serving needy populations. States can develop more sensitive state specific measures of need than can help CHCs retain their designations.

2. Does the investment of state funds into program areas cited in your testimony, mean states are going to spend more money for primary care?

   a) We are pointing out what has been the historical funding patterns established with respect to other federal programs where some state ownership has been created by virtue of state administration. With respect to what states will do in the future for primary care, we can only describe what has occurred in Michigan. The state has been supporting CHCs for 14 years and state funding has increased on a steady basis over these fourteen years. However, the state does not spend enough to meet the unusually stiff match currently required.

3. Are states now interested in primary care since they have not been historically?

   a) We should not forget, the very first CHCs were started by staten and local public health agencies - New York. There is much evidence to indicate states are beginning to assume a much more active leadership role with respect to primary care issues.

      First the need for health care cost containment is forcing them to take a harder look at how to develop primary care systems.

Second, states are beginning to incorporate a comprehensive, continuing care philosophy into their MCH, chronic disease program efforts. There is state recognition that this is essentially a primary care approach to service delivery. Interest in CHCs is a logical next step.

The fact that a majority of states have signed MOAs with HHS to engage in joint primary care planning is an indication of growing interest.

4. How will changes in statue allow states to take block?

   a) Match more reasonable
   b) States not responsible for making up federal share
   c) More flex in designation
   d) Funds under 1921 could be used to develop state capacity to develop administrative abilities

5. What aspects to previous legislation created barriers?

   a) Excessive match
   b) Financial risk for unknown federal appropriation by maintenance effort
   c) No administration monies - requiring state appropriations - couldn't build own bureaucracies when cutting back on programs

6. Why is it important to have states involved?

   a) States can develop expertise in primary care
   b) States can leverage health care system for CHC through regulation, state-education of health manpower, training programs, Medicaid Financing Policy

MDPH/DHCS
3/84

The **Chairman**. Thank you so much, Ms. Chabut.

Mr. Wilhide.

Mr. **Wilhide**. Chairman Hatch and members of the committee, my name is Steve Wilhide.

I am representing the National Rural Primary Care Association—NRPCA—today as a member of the board of directors. I am also executive director of the Southern Ohio Health Services Network, a nonprofit community-based organization funded in 1976 to address the problem of inadequate primary health care services in four Appalachian counties in Ohio.

Initial funding for the Network was from the Appalachian Regional Commission and the Community Health Center program of the Public Health Service. The Network currently operates six medical and two dental centers in this underserved area.

Let me turn now to the situation in my home in southern Ohio. Today, unemployment and poverty in this area exceed the rate of 1976. In Adams County, the unemployment level exceeds 20 percent; a year ago it was about 33 percent in that county. Public assistance programs are provided to another 27 percent of the population in Adams County. The network has two medical and one dental centers in this county, and in addition to patients covered by medicaid, under which the State of Ohio reimburses us only 45 percent of our charges, another 20 percent or so are people who are on a reduced fee based upon income and family size.

In spite of this extensive need, we are currently receiving less than half of our operating revenues from Federal grants. Donations, patient fees and other third-party billing constitutes the remainder. I might add here that this is not particularly desirable. Now that the economy has bottomed out, we cannot get our level of Federal support back up to where it once was, and, as a result, we have been having to curtail services. In effect the network is being penalized for being efficient. Our services are utilized by all members of the community.

Due to the shortage of quality primary care physicians in this area it is not unusual to see the local attorney's wife sitting in the waiting room with her children, talking to a local AFDC mother and her children. We have the only board certified pediatrician in Adams and Brown Counties. The entire community benefits from this program.

For that reason, I believe, we have very broad based community support, and I think this is true in many rural areas of the country where poverty is diffused.

In Brown County, the situation is very similar. Again the network pediatrician is the only pediatric specialist in the county. He is kind of an unusual fellow. He was a very urban oriented individual from Chicago and came to Brown county to serve a National Service Corps scholarship obligation. He found he liked it there, bought a farmhouse and renovated it. He is into gardening now and his friends back in Chicago are amazed at the transformation.

But he is really enjoying it. He is a salaried employee now of the network and a real pillar of stability in the area.

You will find our 12 network physicians very actively involved in such community activities as coaching baseball teams. One physician volunteered to be the clown in the hospital's dunking booth this past summer. They are team physicians for local sports teams. They write "Ask the Doctor" columns for local papers and appear monthly in radio health call-in programs. Network physicians are all very deeply committed to the concept of prevention and health promotion. This is one of our very successful programs through the health promotion initiative of the community health center's program.

We have been real pleased with the community response to that program, including an infant car seat program which has significantly reduced the number of infant deaths from unsecured infants in cars.

Not everyone is obviously inclined toward this kind of rural lifestyle that our friend from Chicago has adopted. Over the past 8 years, however, my experience in recruiting physicians has been that the majority of people coming from the National Health Service Corps are indeed socially committed. They accepted the scholarship not just as a source of sending themselves through medical school but because they believed in the National Health Service Corps and what it stood for.

As a result, although we serve a rather large geographical area, there is a sense of unity and mission among the health care providers in the network.

In spite of the so-called "physician glut" my attempts to recruit outside of the National Health Service Corps have not been very good. I get calls all the time from professional recruiting agencies who want $15,000 a head and no assurance of what we are going to get. The quality of physicians coming through the National Health Service Corps is exceptional and better than I can find on the open market.

This is in spite of a program through the University of Cincinnati Medical School whereby medical students rotate through our rural health clinics. The students who seem to express an interest in ultimately coming to work for us are those who have National Service Corps obligations.

As the GEMANAC report concluded a few years ago, while there may be physician glut in coming years, the National Service Corps program is a key resource to assure inaccessible rural and isolated communities have adequate medical manpower.

The National Rural Primary Care Association is very appreciative of the introduction of Senate bill 2281 to reauthorize the National Service Corps, including the scholarship program. We do not feel that 150 scholarships is adequate to meet the need, however. It is safe to assume 10 percent of the scholarship recipients will drop out of the program for whatever reason, and another 20 percent will choose a private practice option in areas that are not necessarily those of highest need. We feel perhaps a more adequate scholarship number might be 300.

Finally, I would like to address Senate bill 2308. Again, the National Rural Prime Care Association is very appreciative of the introduction of this legislation to reauthorize and extend the community health center's program. We feel the funding levels are realistic in this period of austerity.

Both of these programs provide very critical services to medically underserved populations. We have seen an improvement in the administration of this program through the Federal-State partnership. I might say that in Ohio there was not one single staff person in the State government who had any knowledge whatsoever in primary care prior to this joint effort.

I have been very involved with the Governor in developing that capability. So, I think bringing States into the process at this point has been helpful. I think it has been an education process for the States to be included in the administration of the program.

We feel that this alliance will help assure the long-term viability of these community based programs. So, the National Rural Primary Care Association strongly supports the increase in the State role in the administration of both the National Health Service Corps and the Community Health Center program.

We are a little concerned, however, with the community health center program in a block grant. As a national organization representing diverse rural health institutions—hospitals and other kinds of services—we are committed to the principle of equity in services. We are concerned while that in some States may continue to expand rural primary care, others may use the funds in lieu of current State or local funds.

We are concerned also that funds might be allocated on a per-capita basis as opposed to need, as is the case in Ohio with public health dollars. As a result, Adams County, which has the highest poverty and the highest unemployment in the State, gets such a small level of State funds they can only support a part-time nurse and a part-time receptionist in the local health department.

Consequently the south Ohio Health Services Network has had to carry out many of the other traditional public health department kinds of programs. I will say, however, I feel our approach is perhaps more desirable because rather than having an immunization clinic once a month and a hypertension clinic once a month, we are providing family-oriented primary care and it is comprehensive. We do not feel that patients or families should be treated on the basis of a specific disease, rather on the basis of total health care.

The NRCPA also believes people should have adequate and accessible primary care services regardless of the State they live in. I am sure you are very aware of the fact that medicaid programs vary significantly from State to State. In Ohio, there is some confusion as to whether a woman who has not previously been on ADC who is pregnant for the first time can get prenatal care prior to her sixth month because she is not eligible for ADC until 6 months. So, there are some real concerns about that type of inequity across the States.

Finally, the National Rural Primary Care Association advocates local control of health centers through consumer boards. We feel that this goal is assured through the current categorical administration of the program.

We are very appreciative of the introduction of both Senate bill 2281 and Senate bill 2308 to reauthorize the community health centers program and the National Service Corps. We feel the introduction of these bills is testimonial to the effectiveness of these programs in assuring a national commitment to high quality, accessible primary care services to all of our citizens.

I have also brought with me, a letter from the Governor of the State of Ohio in support of the reauthorization of both of these programs, and I would like to add that to the record if I may.

The CHAIRMAN. Without objection, we will put it in the record at this point.

Mr. WILHIDE. Thank you very much.

[The prepared statement of Mr. Wilhide follows:]

National Rural Primary Care Association

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TESTIMONY OF

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ON BEHALF OF
THE

NATIONAL RURAL PRIMARY CARE ASSOCIATION
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BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

CONCERNING

S.2281 AND S.2308

REAUTHORIZATION OF
THE
NATIONAL HEALTH SERVICE CORPS,
PRIMARY HEALTH CARE SERVICES

ON

MARCH 7, 1984

Chairman Hatch, and members of the Committee, my name is Steve Wilhide.

I am representing the National Rural Primary Care Association (NRPCA) today as a member of the Board of Directors. I am also Executive Director of the Southern Ohio Health Services Network, a non-profit community-based organization founded in 1976 to address the problem of inadequate primary health care services in four Appalachian counties in Ohio. Initial funding for the Network was from the Appalachian Regional Commission and the Community Health Center program of the Public Health Service. The Network currently operates six medical and two dental centers in this underserved area.

Let me first say that the NRPCA strongly supports continuation of the National Health Service Corps and the Community Health Center programs. These programs provide services that are critical to the interests of medically underserved populations, many of whom live in rural areas of our country. These programs are well managed both at the federal and local level with a continuing trend toward management improvement at both levels. One aspect of this improved management is a growing partnership between federal and state governments in the administration of these programs. NRPCA feels that this alliance will help assure the long term viability of these community-based programs.

With that in mind let me now turn to the situation in my home in Southern Ohio. Today, unemployment and poverty in this area exceeds the 1976 rate. In Adams County, with an unemployment level exceeding twenty percent, "economic recovery" is an elusive dream. Twenty-seven percent of the population are recipients of public assistance programs. The Southern Ohio Health Services Network has two medical and one dental program in Adams County. In addition to patients covered by Medicaid (for which the State of Ohio pays about 45% of charges) twenty percent are on a reduced fee basis because of low incomes relative to their family size.

In spite of this extensive need, the Network receives less than half of its operating revenue from federal grants. Donations, patient fees and other third party billing constitutes the remainder. Due to the shortage of quality primary care physicians, all community members avail themselves of our services. It is not unusual to see a local attorney's wife and children talking with an ADC mother and her children while waiting to see our National Health Service Corps pediatrician, the only Board Certified pediatrician in Adams County.

In Brown County, the situation is similar. Again, the Network pediatrician is the only pediatric specialist in the county. He was recruited through the National Health Service Corps Scholarship program four years ago from Chicago. Today he is salaried by the Network, lives in a renovated farmhouse off a back road and enjoys gardening and watching the wide array of wildlife that feed near his house. All of the twelve physicians and four dentists working in the six Network centers live in the communities where they work. They are team physicians for the local schools, football and basketball teams, have "ask the doctor" columns in local papers and radio call-in shows. They can be found staffing health fairs, teaching classes on hypertension and diabetes to individuals and families and serving as leaders for church youth groups. I can't emphasize enough how important these providers are to the areas they serve.

Not everyone is inclined toward a rural lifestyle, and physicians and dentists are no exception. My experience in recruiting, over the past eight years, has demonstrated that the majority of health professionals choosing the National Health Service Corps, whether through the scholarship program or as volunteers, are indeed socially committed and motivated. They want to do what they do best; provide quality health care to all who seek to be served regardless of ~~social~~ or economic status.

In spite of the so-called physician "glut", I have not had much success recruiting outside the National Health Service Corps. This is in spite of linkages with the University of Cincinnati Medical School whereby students spend a given period of time working in our Centers with our physicians as preceptors. Those who do express an interest in ultimately working in the Network are usually National Health Service Corps scholars. This situation is verified by many of my rural colleagues who report similar recruiting problems. If there is a "glut", it certainly is not apparent in the poorer rural communities served by our programs.

Generally speaking, recent National Health Service Corps policies have been favorable to rural areas. Working with the States, the Corps has recently developed a Health Manpower Shortage Area Placement Opportunity List (HPOL) which targets National Health Service Corps providers to areas of greatest need. The HPOL has relieved problems caused by the Private Practice Option (PPO) which made recruiting in the most needy rural areas more difficult. Given absolute freedom of choice, young Corps' physicians tended to select urban or suburban sites which were not necessarily the areas of greatest need. For example, two physicians placed before the advent of the Placement Opportunities List are currently serving their National Health Service Corps scholarship obligations in PPO sites near Cincinnati barely inside a Health Manpower Shortage area. One works for an urgent care center operated by a large proprietary chain; the other is with a private medical group, less than five minutes from the Cincinnati areas, newest shopping mall.

The places where a Corps-obligated physician can serve must be prescribed by the HPOL, and that provision should be included in the current legislation to assure that providers go to the sites where they are most needed.

The National Health Service Corps is a critical resource to assure adequate and accessible health care to underserved rural areas. As the Graduate Medical Education National Advisory Council (GEMANAC) report concluded, many small rural communities will not benefit from the physicians surplus. This report, commissioned by the Department of Health and Human Services, advocated continuing the National Health Service Corps to meet the medical manpower needs of rural underserved areas. The National Rural Primary Care Association appreciates the support that the Chairman's Bill (S.2281) provides to the NHSC. NRPCA strongly supports the three-year reauthorization of the National Health Services Corps, including the scholarship program. However, we do not feel that 150 scholarships is adequate to meet the needs. We feel a more adequate number would be at least twice that number (300). This would provide an adequate base upon which to build a strong field service corps.

Finally let me address S. 2308. NRPCA shares the Chairman's and the Committee's concern for the provision of primary health care services. We support the reauthorization of the primary care programs under Sections 329 and 330, The Migrant Health and Community Health Center programs. We also believe that states should have a role as partners with the Federal Government in the support of primary care. Over the past several years some progress has been made in involving States in primary care through memoranda of agreement. While there has been little formal evaluation these federal-state relationships, it is safe to say that there is great variation in the abilities and commitments of States for primary care. This variability among the States in their primary care efforts is one of the factors that makes the whole issue of the Primary Care Block Grant an extremely complex one.

The NRPCA membership is divided on the Primary Care Block Grant issue precisely because it is so complex and so much is at risk. We have not as an organization taken a position on the specific provisions of S.2308 which deal with the Primary Care Block Grant, so I am not at liberty to address them in this testimony. We will be meeting in about two weeks to try to develop a consensus. NRPCA is on record, however, supporting the types of restrictions that are on the Block now. The Block must remain optional and restricted to protect the integrity of existing community-based, comprehensive primary health care programs.

The NRPCA believes people should have reasonable access to high quality, comprehensive primary health care services regardless of the state in which they live. Through categorical federal programs such as Community Health Centers and Migrant Health Programs this goal can and is being achieved. The NRPCA also advocates local control of health centers through community-based consumer boards. This goal is likewise assured through the current administration of the Community Health Centers and Migrant Health Centers Programs.

In summary, the National Rural Primary Care Association appreciates and supports a large part of the contents of S. 2281 and S. 2308. We would urge the three year reauthorization of the NHSC, proposed by Senator Hatch, with an increase to at least 300 the annual number of scholarships. National Rural Primary Care Association also asks that language be included which would mandate the use of the Practice Opportunities List in determining sites eligible for NHSC placements. We also strongly support the reauthorization of the Migrant Health and Community Health Centers Programs as catergorical authorities. We would urge you to consider higher funding levels over the next three years, however, because of the high degree of need which remains in the populations served by Community Health Centers and Migrant Health programs. While National Rural Primary Care Association strongly supports state support for an involvement in the provision primary care services through memoranda of agreement, we are not prepared to address the specific provisions of S. 2308 relative to the Primary Care Block Grant.

There's a philosophy in rural Ohio which was cited in our testimony in 1980 in support of the reauthorization of The Community Health Centers Program which still applies: "If it works, don,t fix it."

Thank you very much for the opportunity to testify.

The CHAIRMAN. Thank you.

Ms. Chapman, let us turn to you.

Ms. CHAPMAN. Good morning, Mr. Chairman, Senator Kennedy. If you do not mind, in order to make myself feel a little more comfortable with you, I would like to greet you like I would if you were down home: "Good morning, you all, how are you doing"? [Laughter.]

The CHAIRMAN. We are happy to have that.

Ms. CHAPMAN. I am the executive director of the Tug River Health Clinic located in Gary, WV.

The State of West Virginia currently has an unemployment rate of 15.9 percent. McDowell County's is at 25 percent, and the town of Gary's unemployment rate, we are happy to say, has dropped from 90 percent to 70 percent in the last several months.

The Tug River Clinic is a rural health clinic established in 1976 through a Rural Health Initiative Grant from the Federal Government to serve the people of our county, focusing on the low-income and disadvantaged population.

Before the clinic was established, our people traveled as long as 1 hour over mountainous terrain to visit a hospital emergency room. But through the clinic we are able to offer high-quality, comprehensive health care at a much lower cost to the 5,000 people we serve.

I am speaking to you today as the director of a clinic from the only State in the Union that opted to take the primary care block grant and to explain why, along with virtually all other health center representatives not only in West Virginia but throughout the country, I feel that the primary care block grant was a mistake from the beginning and one which needs immediate correction from you and the Congress.

The National Association of Community Health Centers' written statement, submitted to you, talks about the excellent job community health centers have done under uniform Federal management guidelines and policies over the past 15 years.

Despite this fact, Congress in 1981 created the primary care block grant, giving States the option to take over this program. Those supporting the primary care block grant said they believed States could do a better job of administering the program and that the people would be better off under more local control.

In our experience, just the opposite has been true. In fact, in a recent letter to the director of the Health Department of West Virginia, our Governor explained the inadequacies in the program and instructed the director to return the management of the health centers back to the U.S. Department of Health and Human Services.

Under vague block grant regulations, the Department of Health and Human Services provided no guidance to the State and left the door open to abuse and confusion. As a result, the State of West Virginia failed to guarantee the centers their minimum funding levels guaranteed them by law.

This resulted in a court case—wasting money, time, and energy—just to have the law enforced as it was written and to ensure that the health centers would get their full entitlement.

State management problems that were experienced under the block grant program have been somewhat hard to deal with. Even though the West Virginia State Legislature passed a bill which would allow advance payments to the clinic, we are now experiencing delays of 1 to 2 months in order to get our operating cost for 1 particular month.

If I invoice the State on the first of February for my March check, I am lucky if I get my March invoice by April. This creates some real cash-flow problems for us.

Another problem we have experienced is that the State government—throughout the State government, not only the health department—has simply not had in place the system that is required to meet the administration of this block grant. I have had to go to the extent of calling the State auditor's office myself and spending as many as 2 hours on the phone, trying to track down my invoice, find out where my check is. Is it in the treasurer's department? Is it in the auditor's department? Is it still in a basket at the State health department? I have actually spent 2 hours on the phone and have had to have my senator make a call to try to track down my money, to find where it is going to be so that I can meet payroll the next day.

One of the big problems I have really been concerned with for the last 2 years, before the State actually took the block and now that the State has had the block, is the political implications on the local level. I do not know about other States, but the State of West Virginia has a very strong political base as far as the local communities are concerned. It is not what you know or what your clinic does, but who has the most influential senator sitting in the State legislature; that is how you get your money.

It is who you know and not what you do. One of our real concerns is that a lot of the centers would suffer because some people would have more local influence with their State senator than others, whereas the weaker clincis may really need the money much more.

So, the local political implications have been a real problem for us.

Economically, the primary care block grant has locked West Virginia into a fixed percentage of national funding, regardless of changing conditions. For example, during the 1982 recession when West Virginia had the highest unemployment rate in the nation, we would have lost $200,000 in Special Jobs Bill money had we been operating under the Block Grant.

Second, the State actually lost $600,000 in 2 fiscal years because of an arbitrary decision in calculating West Virginia's share under the block grant, which has forced us into yet another court case.

In conclusion, Mr. Chairman, we believe the primary care block grant is a mistake in any form. It is bad medicine for the health centers and the people they serve.

I want to thank you for the opportunity to be able to speak to two such distinguished members of the U.S. Senate. I hope that what I have said will have some impact on this decision that is going to be made, and I will be happy to answer any questions that you might have.

The CHAIRMAN. Well, thank you. We are happy to have all three of you here, and I have listened carefully to all of your testimony on the primary care block grant and my bill, S. 2308, the primary health care amendments of 1984.

I really have to say that I am enormously impressed with the commitment that the State of Michigan has to primary care. With the changes that we are proposing in this bill, it seems to me they have a deep desire to work under a primary care block grant and I feel it is important that they have the opportunity to do so.

But I also note with some wonder the incredible, and I believe unjustifiable, fears expressed about the block grant by some community health centers.

I find it hard to reconcile those fears with the obvious credibility and good intention of Ms. Chabut here in the State of Michigan. But I am going to listen and make sure that we keep an open mind on this.

But I would like to ask each of you panel members to respond to this question:

What specific statutory or report language can we adopt to assure that Michigan and other interested and qualified States can choose to assume the primary care block grant with necessary flexibility, yet provide reassurance to community health centers that their fears are unjustified?

Basically, I want to know how we can work together to make the primary care block grant concept a success in those States where its implementation is appropriate and desired by the States, while not raising unnecessary fears elsewhere.

Let us start with you, Ms. Chabut and then Mr. Wilhide, and then Ms. Chapman.

Ms. **Chabut**. Well, I think that it has been probably clear that the assumption of a block grant and the intention to work with community health centers is not something that every State would want to go through.

I think I am talking about Michigan, who is interested and committed to the process of working with our community health centers. I think some of the safeguards could be found in the block are the 330 statute where you would continue to spell out the characteristics of the Community Health Center Program.

You would continue to require the community governing structure. There would continue to be Federal approval of MUA's as well as a clear Federal oversight of the way in which the States were working with the Community Health Centers as they assume the block.

I certainly have heard in the testimony from West Virginia that there just has to be a pretty clear definition of what the authority and the relationship is between Federal and State levels of government. It would be essential to spell that out pretty clearly.

I heard also the need for a clear sitting down between the States that were interested in pursuing the grant with their local community health centers in order to work out the kind of administrative processes and procedures that would be considered by the community health centers to be appropriate safeguards.

The **Chairman**. You kind of see it as a State leadership problem so that things are equal and fair, and the procedures are well defined and outlined.

Ms. **Chabut**. I think that it has to be, that has to be true, yes. I also think that most States would be anxious to fulfill what is Federal intent, congressional intent. I know, speaking for Michigan, that we would be very pleased to sit down with a group of folks to work out what might be the appropriate safeguards that should get built into the reauthorization.

The **Chairman**. Thank you. Mr. Wilhide?

Mr. **Wilhide**. I have several comments.

One, I think the comment that Ms. Chapman made, "it depends upon how powerful your State representative or senator is," is very real. It is very real in the State of Ohio. I think my concerns 3 years ago with our then Governor was that somehow primary care would be interpreted as putting flush toilets on the interstate because we currently have pit toilets. [Laughter]

Mr. **Wilhide**. That was a very real concern. I mean, the pits are the pits, no question about it. But you know, the priorities are a little higher than that. So I had a great deal of concern about how primary care is defined.

I think primary care is clearly defined right now. The mandated and optional services a community health center must offer is clearly spelled out in the Federal Register.

It seems to me just from what I read of the problems with the block grant that HHS said to the States: "OK, here is the money, no strings attached." There were really no detailed guidelines to be followed. The kinds of problems that Ms. Chapman encountered should not have happened, in my opinion.

But then again, I wonder if you institute that degree of detail to assure the intent of Congress is being met, are you then introducing yet another layer of bureaucracy?

So, I do not know, it is a tough question.

The **Chairman**. They should be doing it on the State and local level where the people should be responsive. That is the argument, anyway.

All right, I did not mean to cut you off.

Mr. **Wilhide**. That is OK.

I guess the other concern that I would have would be the State's ability. I think this thing was thrown open to the States. As I indicated, Ohio does not have anyone with expertise in primary care. In some States, let us face it, the State medical society does not feel the State has a role in providing primary care. So, you have that going against you.

In the State of Ohio we had a very tragic case where an infant was referred by a National Service Corps doctor in Pike County to the nearest county where there was a pediatrician, in Ross County. The pediatrician on call, on call would not come into the ER to see that infant because the family was on medicaid, and the infant died about 4 hours later.

In the same county there is not a single physician who accepts a medicaid card for obstetrical care and women are going to the emergency room in labor.

These kinds of problems have not been addressed by the State adequately and I have some real concerns—and again the concern of equity. Look at the ADC grant in the State of Mississippi versus New York, for example, as a case of geographical inequity.

I feel that health care, basic health care services, should be defined and available as a right for everyone, and I feel the scope of services available should be nationally determined. That is my personal feeling. I have a real concern that the State in which a person lives will determine whether health care will be available or not to low-income people.

The **Chairman**. Ms. Chapman?

Ms. **Chapman**. I am going to try to answer if I remember the question. [Laughter.]

I think I lost track of what they were saying. But I want to say at this point, with all due respect, I do not think that there is any other State that has any more commitment to primary care than the State of West Virginia—the State government, the health department, the Governor's office. I do not think there was any more commitment anywhere than those people had.

The problem for us was that the system was simply not there. Other States might be different. West Virginia, I feel, did not have the system that was adequate enough to monitor and evaluate our program, and to be able to keep local politics from playing a role in that program.

You know, State by State, I realize it differs. Maybe other health departments are more capable of handling the administration of this program. But in our State it just was not that, it was not a question of commitment from the department of health or the State government.

So, my only recommendation would be to continue with the reauthorization of the Federal program and to allow the centers to continue to work with the State health departments and State governments to provide as much primary care as we can to the people, with the State health departments in one category, perhaps, and with the Federal Government through the community health centers in another.

The CHAIRMAN. Thank you.

Ms. Chabut, let me direct a few questions to you, and then I will direct a few questions to each of you.

How will the changes proposed in S. 2308 make conditions better for community health centers in Michigan, in your opinion?

Ms. CHABUT. Well, I think that it probably helps to create a sense of State ownership as well as commitment in helping community health centers to solve the problems in the States.

There is the obvious increase in funding through the match that would be required, and I think that State involvement would probably be quite sensitive to the CHC concerns and perhaps better able to maintain the kinds of close communications that would be required for that kind of problem solving.

The CHAIRMAN. I see. The concern has been raised that States have historically had little interest in the provision of primary health care to indigent populations.

Therefore, would States make attempts to redistribute CHC funds in a less equitable manner than the Federal Government, in your opinion?

Ms. CHABUT. Well, I think that goes back a little bit to the issue before on the kinds of safeguards that have to be built in. I do not think that that would happen. I think that the States would respect congressional intent.

I think, again, that the reference to the 330 statute already included in S. 2308 requires the continuation of certain basic important features of the CHC program as well as the anticipated Federal oversight role, would help to put the necessary safeguards and checks and balances into place.

The CHAIRMAN. Let me just ask a couple of questions on the National Health Service Corps.

As 1 of the 28 States that are participating in the National Health Service Corps State demonstration projects, what NHSC responsibilities have Michigan and other States assumed?

Based on Michigan's experience, what are the positive and negative pictures of the demonstration project and, in your opinion, how can the project be improved?

Ms. CHABUT. Well, I think that there was excellent intent in establishing the State-Federal partnership in the National Health Service Corps. The contracts that get developed do permit some flexibility between the States with respect to the degree of responsibility as well as the interest in various facets of management.

It provides States with resources to begin developing their own expertise in solving related manpower problems at the State level.

I think States have some inherent capability, perhaps, to make more sensitive and less arbitrary kinds of decisions than the Federal Government because what constitutes good, sound Federal policy at the national level can be brought closer to home on a smaller geographic level by the State.

We have enjoyed the participation in the matching of assignees to health centers. We think that that has been a real strength in the program.

I guess that the liability, of course, is in the aspects of needing to place physicians in areas that they may perceive as being less than optimal or less than highly desirable, but I think that States are quite willing to get involved in that kind of a situation because you can see that you are doing some community health capacity building and that it makes sense. States are willing to do this, if the Federal Government stands behind the recommendations the State has made and respect the terms of the contract.

The CHAIRMAN. Do the States, in your opinion, feel that they have adequate input into the health manpower shortage area designation process, so that the National Health Service Corps assignments are being made to the areas of greatest need?

Ms. CHABUT. Well, with respect to both MUA and HMSA designations, the States really now have input in the sense that the HSA's and the State planning agencies are asked to initiate requests and they can review and comment on the lists.

The problem comes up when the gross criteria for measurement that is necessary for national consistency are applied to smaller geographic areas that have some unique kinds of problems. Neither HMSA's nor the MUA measurement measure problems of access that State governments and local communities may be aware of.

You have situations, for example, where a community, an area that has a small pocket of poverty and need in it might be adjacent to a more affluent area, and that kind of washes away, according to the Federal designation methodology, the need. But it is a very real need.

So, I think that is the kind of thing we feel that the primary care grant legislation would be helpful in solving that problem by having the Governors built into the appeal process.

The CHAIRMAN. In your statement you describe an initiative in Michigan to create a community health center system similar to the Federal program.

Could you elaborate on this program and tell us how the Federal program would interface with this State initiative should Michigan become involved in the primary care block grant?

Ms. CHABUT. Yes; Michigan has been involved with funding community health centers since about 1970, and the interest in funding those centers in Michigan was developed primarily because of State legislative interest in the problems of access to care, much as it has in Congress, I think.

State funds are used in pretty much complementary and not competitive fashion in areas that are usually quite marginal or not eligible for MUA designation.

What often happens is that we find we have at least three or four grant applications for every project that successfully achieves either State or federally funding, and so we feel that we would have the opportunity, if we were administratively involved with both the Federal and the State programs to make them work in a better planned and more coordinated fashion.

The **Chairman**. OK.

Mr. Wilhide, your testimony seems to reflect some division within the rural health clinics community regarding stronger State involvement in the administration of community health centers in that particular program.

Now, is that true, and could you explain the reasons for the support or nonsupport of the block grant concept?

Mr. **Wilhide**. Well, the National Rural Primary Care Association is composed of State offices of rural health, rural hospitals, as well as rural clinics. Therefore, we do not have a clear consensus of opinion among our membership as to whether this is good, bad, or otherwise indifferent.

I do feel there are some States, as Michigan for example, that have historically been involved in primary care. Prior to this initiative, this legislation, Michigan was involved. I think in those kinds of cases there is a clear track record and apparently things are working.

However, the majority of States that we are aware of do not have this kind of capacity. I see States beginning to get interested in and developing this sort of capacity. Where it is going to go yet, I do not know. I think that is a major concern of many of us; there is no record to stand on in terms of States and what they are going to do with these programs.

There is a real concern about lack of adequate protection, I think, to assure rural primary care services are delivered to the areas of highest need.

The **Chairman**. Now, you have addressed a concern that States under the block grant may distribute funds according to population criteria rather than need.

If this were indeed the case, could you propose legislative language that would benefit the rural centers without causing a similar inequitable situation with regard to urban centers?

Mr. **Wilhide**. Sure. I think the population criteria, for example, the county neighboring Cleveland is a heavily populated, fairly affluent county and they get a lot of money for the local health department. They, in my mind, do not need that level of funding, whereas the inner city of Cleveland could certainly benefit from that level of funding. The same thing applies to rural areas.

So, I think perhaps some of the same criteria used in the MUA process and the HMSA designation process could be used to determine levels of funding, and that these criteria be built in as a protection, strictly prohibiting per-capita distribution of funds.

Again, it is a matter of finding a way to target areas of highest need.

The **Chairman**. If your network had the funds to pay average physician salaries for your area, would you be able to recruit physicians without the NHSC?

Mr. **Wilhide**. In counties that are not more than, say, 45 minutes drive from the city or suburban area, I have been able to do this. However, in counties and towns that are at least an hour or more away from the nearest shopping mall or urban-suburban area, the answer is no. It has been difficult even through the National Service Corps to be able to recruit because there have been fewer people available.

So, the problem continues to exist.

The CHAIRMAN. Currently, the National Health Service Corps awards scholarships to help professionals while they are attending health profession school. This results in a long delay, in some cases, 7 years, between the time an individual first receives a scholarship and the time that the individual begins fulfilling that particular scholarship obligation.

Now, do you think that the Corps would benefit from obligating health professionals during their residency or advanced clinical programs, rather than during their formal education?

Mr. WILHIDE. Of course, the time of their formal education is when they need it most. The people that I have been able to recruit, by and large, could not have attended medical school without the NHSC scholarship. For example, an internist at one of our Adams County centers is a second-generation Mexican-American. His father speaks very broken English. He is very grateful for the National Service Corps program. He told the regional office he would go anywhere they wanted to send him.

A long-standing physician vacancy in Adams County has therefore been filled. He could not have made it through medical school without the NHSC program. Now, if there were some way of saying, "Well, you can take out a loan during medical school and perhaps during your residency you can get a National Service Corps scholarship that will retroactively pay," or something like that, that might be more beneficial.

But I do feel that the time of greatest need is when these fellows are in medical school. There are some problems that you are addressing and I respect those problems.

The CHAIRMAN. All right.

Ms. Chapman, in your testimony you state the National Service Corps placements should be to the highest-priority health manpower shortage areas. But that the Secretary should be required to consider problems of access to care as well as geographic distribution in determining need.

Now, could you explain in more detail what you mean by, "The Secretary should be required to consider problem of access and geographic distribution?"

Is that not being done now, in your opinion, or what needs to be done?

Ms. CHAPMAN. I do not know what testimony you are referring to, the one I just gave on the primary care block grant?

The CHAIRMAN. Your written testimony that you submitted.

Ms. CHAPMAN. The written testimony?

The CHAIRMAN. Yes.

Ms. CHAPMAN. I do not have a copy of that with me.

The CHAIRMAN. All right. Well, let me submit that to you, and if you can get us your answer to that I would appreciate that.

Ms. CHAPMAN. Yes, I will be happy to do that.

[Information supplied follows:]

MS. CHAPMAN'S RESPONSE TO SENATOR HATCH'S QUESTION

The problem, Mr. Chairman, is that the NHSC currently distributes its resources (health professionals) solely in response to availability problems. Simply put, if an area or population has less than one physician for every 3,500 residents, it is a candidate for NHSC assistance. If, however, it has greater than one primary care physician for every 3,500 people, it does not qualify.

On the other hand, the simple availability of a physician (or dentist, or whatever) does not in any way assure that the people will then have access to those services. Many studies, most recently one by the Robert Wood Johnson Foundation, have shown that poverty, or low economic status, is the single most significant barrier to gaining access to health care.

While measures of poverty and infant mortality currently have some impact in determining whether an area qualifies for NHSC support, it is far from adequate. I firmly believe that these measures should have much greater impact, that access to care should be taken into account and not merely "geographic distribution", or physician-to-population ratios.

The attached paper makes some specific recommendations, which I strongly endorse.

The **Chairman**. Let me just take a second or two to further discuss the West Virginia experience with the primary care block grant.

The primary care block grant requires States to match Federal funds provided under the block. In its first year, West Virginia appropriated $800,000, as I understand it; the second year $1.4 million; and in the third year $1.8 million to meet the matching requirement.

Now, this funding is a supplement to the Federal grant moneys provided to the community health centers, money that would not have been available to the community health centers in West Virginia had the State not become involved in the program itself.

Now, has the Tug River Center applied for and received supplemental funding under this block? Has the additional funding—if it has, has the additional funding been helpful to your center?

Ms. **Chapman**. OK, first of all, let me just say that the additional funding that was added to the State budget for primary care was not necessarily to meet the match for the block grant.

I mean, there is money in the budget, in the primary care line item of the State health department's budget for primary care. It is not necessarily to meet the match for the block.

As a matter of fact, even though the Governor has returned the block to the Department of HHS, there is still $1.8 million in the State budget for primary care.

As a matter of fact, about a year ago last April or May, I did apply for a supplemental request. Actually, I applied to HHS because at the time the Federal Government was still administering the program because of a Federal court injunction against the primary care block grant. I applied to the Department of HHS for a supplemental to take care of the needs of the higher unemployment. At that time, McDowell County had an unemployment rate of 43 percent. And when I applied to the Department of HHS for the supplemental, the State health department did come in and want to give me half of the supplemental request. And I did receive $57,500 for which the people in Gary were very grateful.

The **Chairman**. I see. Will, the federally funded CHCs in West Virginia actually lose supplemental funding now that the State is no longer required to funnel State matching funds directly to former Federal grantees. Will you lose funding?

Ms. **Chapman**. No.

The **Chairman**. OK. Are the Tug River Center and other established centers in West Virginia, willing and ready to share these supplemental dollars with some 63 other sites basically in West Virginia?

Ms. CHAPMAN. Well, we did share them. Under the primary care block grant the State health department funded several organizations that were not originally federally-funded health centers with it matching share of the block grant money.

The CHAIRMAN. OK. Your testimony states that, "Due to the block grant, better relations exist between the State health department and the CHCs."

Do you feel that these improved relations have been beneficial to the centers?

Ms. CHAPMAN. I am not sure I understood or heard the question very well.

The CHAIRMAN. Yes. In your statement, your written testimony, you stated that, "Due to the block grant, better relations actually presently exist between the State health department and the CHCs."

Do you feel that those improved relations helped your centers?

Ms. CHAPMAN. Not my center in particular, no. And it does help the centers, you know—and when I speak of centers, I am concerned about health care all over West Virginia——

The CHAIRMAN. I see.

Ms. CHAPMAN [continuing]. And not Gary, and I was speaking more to the centers who, you know, had not initially received a 330 grant and was able to get money from the State health department through the matching funds.

[Additional information supplied by Ms. Chapman follows:]

ADDITIONAL RESPONSE BY MS. CHAPMAN TO QUESTION BY SENATOR HATCH

I have received the written testimony, submitted by the National Association of Community Health Centers, Inc. and can not at any point find the quote used by the Chairman. The only reference to relationships between CHCs and states is found on page 8 of the written statement:

"Local Community Health Centers have developed excellent working cooperative relationships with State officials, in compliance with the Congressional intent found *in the categorial Community Health Center legislation.*" (emphasis made)

Clearly, the intent of this statement, both on its own and in the context of the entire NACHC statement, is to show that, under the Federal categorical program, CHCs have worked well with the states. I support both the intent and the thrust of that statement, which clearly implies that we do not need a Block Grant in order to encourage close working relationships—they already exist under the current (federally-managed) system.

The Chairman. OK.

Senator Kennedy.

Senator KENNEDY. Thank you.

It has been a very helpful and useful panel, and I want to thank all of you for your presentation.

One very compelling conclusion that I reach is that the existing program is working, and working pretty well. And I think, as Mr. Wilhide mentioned earlier, if it's not broken, why try and fix it? I think Ms. Chabut from Michigan has indicated that it is working well in their State and that they have the memorandum of understanding, a strong commitment in that State in terms of both community health centers as well as in primary care, and there can be perhaps an even greater effectiveness with some additional kinds of flexibility.

But it would seem to me it would be the height of folly, in order to achieve those gains which I think are certainly desirable and worthwhile, if we were to try to restructure or reorganize this program in such a way as to undermine what has been an effective program.

I have not heard during the course of these hearings where the Federal Government has either established health centers in areas where they should not have been, or objections by local people about the procedures that have been followed. I think all of us would obviously like to expedite the process and the procedures. I am sure we would like to have more efficiency in terms of the funding. A good deal of that blame comes right back here to the Congress because of our delay in getting appropriations up and the rest.

But I have been listening to these comments here this morning and am really very reassured about the way that we have proceeded under the Community Health Service Program, and certainly the comments that have been made about the primary care block grant give me reassurance about the importance of establishing some general criteria under some kind of a partnership between the Federal Government and the States so that we can find out what is effective and what isn't effective in terms of the Primary Care Program so that we can come back to the Congress and get expanded funding for those programs that are efficient and effective and discard perhaps those programs that are not really meeting the needs of the people.

And we have the Surgeon General's report to establish an excellent criteria and an excellent start for these programs. And I do believe that Mr. Wilhide's basic summary—that is, that what we should be interested in in our society when we are allocating Federal resources is the fact that where a particular child is going to live, whether he or she is going to get some decent health care is not going to be decided by county line or even State line, that if we find that is an area of need, that we ought to be trying to respond to those particular needs.

So I would hope that perhaps Ms. Chabut would indicate what recommendations could be made to the existing program that might help assist to provide some degree of flexibility. I know she has spent time making some recommendations, but I would hope that she also would agree that we should not be disassembling what has been a pretty effective program across this country, in order to devise a different process or different procedure for funding these programs in these various States.

I do not know whether any of you have any reaction, but I must say after listening to the panel here, I would certainly hope that we could—there are enough programs around this building that should be altered or changed, without trying to tinker or tamper with something that seems to me to be pretty effective.

Mr. **Wilhide**. Senator, if I may——

Senator **Kennedy**. With the exception of perhaps gaining more money to try to do the job a little better. We haven't talked about that yet. I will wait until my chairman comes back. [Laughter.]

That's something that we haven't gotten into today, and I don't want to lose the opportunity to at least give you the opportunity of a quick chance to maybe briefly make a summary comment about what the needs are in the communities.

Maybe if I could just ask the panel to remain here, I could ask Stephen Havas, who is the deputy commissioner, if he could just join the panel up here, we might start off with his testimony. And then as I say, I would just like to get for the record a comment from the panel here when the chairman comes back just on the needs.

Steve is the deputy commissioner in Massachusetts, and if the panelists remain here, unless they have got some time problem, and then as soon as the chairman comes back in, I will ask the others just that last question, and then I will ask that Steve's testimony appear at the appropriate place in the record.

The **Chairman** [presiding]. Yes.

Senator **Kennedy**. Since the chairman is back here [laughter]—I was saying that there is one area of public policy that we did not talk about, and that was the funding levels and what could be done with additional resources to the existing structure and what that would mean in terms of health needs for the people that you are serving. If I could just get a quick comment from each one of the panelists on that issue, I would have no further questions.

Mr. **Wilhide**. Senator Hatch and Senator Kennedy, I would like to give an example of what has happened in our area. Our base grant has remained level for the past 3 years while unemployment and need has increased.

Last year we were faced with a major—and this year—faced with some major decisions about how to allocate our scarce resources in terms of subsidized prescriptions. I attended a meeting of our physicians because we are facing—if it hadn't been for the jobs bill—an enormous deficit this year.

We were trying to establish some priorities, and we got into a discussion of whether we subsidize prescriptions of indigent elderly people whose prescriptions are not covered under medicare and yet those prescriptions are very expensive, versus a child with strep throat and whether he ought to get antibiotics. And at that point the discussion revolved around how expensive the drugs would be for the elderly person and what effect is it going to have versus the child. I had to leave the discussion. I was literally getting sick to my stomach over those kinds of discussions.

I started this program 7½ years ago, and I can't be a part of amputating pieces of it because of lack of funds.

We started a community fund drive. My church has given $1,000. Even my Congressman has given some generous contributions. But it's not enough.

And those are the kinds of problems we are facing.

Ms. **Chabut**. Well, in Michigan I think that we are right now into our fifth year of consecutive double-digit unemployment. Probably everybody understands the economic plight of Michigan as relates to the auto industry. Our State is working very hard on an economic revitalization program.

But whenever you have the kind of situation that we have in Michigan, you know that you have not only the needs of the newly poor that we now need to make an effort to address, but that the plight of the chronically poor is with us as well.

And so every time that we have the opportunity, we have been describing what we've been going through the State as we participate in hearings. We know that our ability to provide basic health care has eroded some in Michigan over the past few years, and anything that we can do to help to bolster that would be very much appreciated.

Ms. CHAPMAN. I guess my story is——

The CHAIRMAN. Bring the mike over a little.

Ms. CHAPMAN. OK. I guess my story is probably pretty similar to the women from Michigan, since Michigan and West Virginia has experienced a lot of the same problems with high unemployment.

Our problem is that in West Virginia our only industry is coal, and when the coal industry shuts down, as it did a couple of years ago, then we're all in poverty. And I include myself in that category.

You know the people are there. They have no place to go. They have no health care insurance. The increased dollars are absolutely essential to take care of these people that no one else will agree to take care of. I mean profitmaking hospitals aren't going to take in 100 or 200 indigent patients a day. They just simply aren't going to do it.

Senator KENNEDY. Your testimony is that there is increased suffering or there are increasing health demands on the particular facilities that you are familiar with——

Ms. CHAPMAN. Both.

Senator KENNEDY. By the people?

Ms. CHAPMAN. That's right. Increased suffering, and increased demands on the centers. In West Virginia the State medicaid program just passed a new regulation that the people having State medicaid cannot go to an emergency room to seek care. So therefore, if they're not being hospitalized, they have to go to one of the centers who will accept medicaid, of which Tug River happens to be one. And our medicaid patient load is increasing tremendously, but our income is not increasing.

Senator KENNEDY. What about it, Mr. Wilhide?

Mr. WILHIDE. We're facing the same thing. Almost a twofold increase in the number of indigent patients that we're taking care of. A lot of the new poor, whose unemployment benefits have run out.

There is a physician—I wish he were here today instead of me because he is a very, private-practice-oriented type of person, but also socially committed. He went to a small town by the name of Bainbridge, which is in our service area, to set up practice. He left 6 months later, in declaring bankruptcy, and with a heavy heart because he could not get patients to go to the hospital for tests that they sorely needed to detect cancer in the early stages because they did not have health insurance and were too proud to go without it, and he was paying for that out of his own pocket.

And I only wish it were he here who is testifying today rather than myself.

Senator KENNEDY. Fine.

No further questions for these panelists.

The Chairman. Well, we are very grateful to have had all of you testify here today. We have received a number of interesting suggestions, and we appreciate having the effort put forth that you have all put forth.

Thank you so much.

Senator KENNEDY. Mr. Chairman, I have a witness, Mr. Stephen Havas.

The CHAIRMAN. Oh, I am sorry. Let me reassemble the committee. [Laughter.]

I am sorry.

You are Mr. Havas?

Dr. HAVAS. Dr. Havas, yes, sir.

The CHAIRMAN. OK. I had not understood that. I apologize.

What we will do is reconvene the committee, and Senator Kennedy would like to get your testimony on the record, and I would also. And I do have to leave, that is my only problem. So I am going to ask Senator Kennedy to put you on the record and ask any questions. And if my staff has any questions, they will submit those as well.

Senator KENNEDY. They may submit those.

The CHAIRMAN. If you will submit those.

Senator KENNEDY [presiding]. Mr. Havas, we are glad to have you here. We appreciate your making the effort to be with us to deal with the subject matters which are before us today. And we welcome you to give us your testimony.

STATEMENT OF STEPHEN HAVAS, M.D., M.P.H., M.S., DEPUTY COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Dr. HAVAS. Thank you very much, Senator Kennedy.

I am Dr. Stephen Havas. I am the deputy director commissioner of the Massachusetts Department of Public Health, and I am speaking on behalf of our department today. I appreciate the opportunity to testify before you on the preventive health and health services block grants. My presentation will focus on three areas: One, the need for increased funding for this block grant; two, the need for targeting that increased funding toward the goals and objectives set out in Healthy People and the 1990 Objectives for the Nation; and three, the need for tracking progress toward those goals and objectives.

Funding for the preventive health and health services block grant should be increased substantially. The States have still not recovered from the setbacks that resulted from the cuts in funding when it was shifted from a categorical basis to a block grant basis.

For example, Massachusetts received 22 percent less funding in fiscal year 1984 than in fiscal year 1981. This reduction in funding has resulted in decreased program efforts in all areas covered by this block grant.

When inflation is factored in, the cuts since fiscal 1981 are even deeper. Our State, like most of the others, has not been able to rebuild these programs through State funding.

Furthermore, the administrative savings which were to accrue to States from block grant funding have not become evident to any of us.

We would recommend an increase of $50 million for the preventive health and health services block grant for fiscal year 1985.

Senator KENNEDY. Let me ask you, some have said that the overflow from the categorical grant helped them pick up the deficit from the reductions in the primary care. What happened up in Massachusetts?

Dr. HAVAS. That did occur in the initial years, but that overflow has run out in most of the States at this point. So we are down considerably below where we started.

Senator KENNEDY. Does that 22 percent just reflect the reduction in the amounts that you have got in the program, or is it the total spending made in the primary care?

Dr. HAVAS. I am sorry, sir, this is for preventive health.

Senator KENNEDY. You say you received 22 percent less funding, but you still must have had some overflow from categorical grants.

Dr. HAVAS. Right. Which has been by and large used up.

Senator KENNEDY. All right.

Dr. HAVAS. Disease prevention programs are critical investments to preserve and improve the public's health. If preventive services are not adequately funded, the health cost for treating diseases which could be prevented will far exceed the savings from limiting block grant funding.

Rather than simply increasing each State's funding under the block grant, the funds should be specifically targeted to address the 15 disease prevention areas outlined in Healthy People and the 1990 Objectives for the Nation. If such targeting is not done, the increased funds are likely to be used in an unstructured manner that minimizes both effectiveness as well as accountability.

For this process to be successful, participating States should be required to prepare comprehensive plans for the use of such funds. In these plans the States should address a minimum of 3 and a maximum of 5 out of the 15 disease prevention areas. Few States would be capable of strengthening or initiating efforts in more than five areas at one time.

Participating States should submit explicit well-reasoned rationale for selecting their priority areas that they will be addressing and specific implementation plans.

In Massachusetts we are currently in the planning stages for a statewide multiple-risk factor reduction program aimed at the three leading causes of death. We chose this approach because it has the greatest potential impact on mortality and morbidity within the State. Together, heart disease, cancer, and stroke cause over 70 percent of deaths in Massachusetts, as they do nationwide. The majority of deaths from these causes are preventable through a reduction in their underlying risk factors.

These risk factors have been well identified and are extremely common in our society, and they are also susceptible to reduction. We believe that a program focusing on the prevention of these diseases could very rapidly achieve substantial reductions in mortality rates. But to implement them, we will require funding that is currently not available in the block grant.

The impact from disease prevention efforts in these 15 areas can be quite large. The impact can also be very rapid. To cite one example of the success of such efforts, Connecticut conducted a 5-year demonstration project for high blood pressure control from 1978 through 1983. That effort was not funded through the block grant but rather through a grant from the National Heart, Lung and Blood Institute. Within 3 years of the inception of that project, age-adjusted heart disease mortality rates had dropped 11.6 percent in Connecticut compared to 5.2 percent nationally.

For stroke, the declines in age-adjusted mortality rates were even more impressive: 28.3 percent in Connecticut compared to 15.5 percent in the United States as a whole.

Those declines continued in the years following that, although they were at a somewhat lower rate.

It is extremely important that participating States not only undertake a planning effort but also closely monitor progress in meeting their objectives. This tracking should focus on changes in risk factors as well as changes in mortality. The States should set quantifiable goals and objctives consistent with the 1990 Objectives for the Nation, and monitor them on an annual basis.

Senator KENNEDY. When did they do that? I mean why not let the States themselves make those decisions and determinations?

Dr. HAVAS. Well, what I was going to say and was not added in there, I think that those objectives should be at least as rigorous as what is in the 1990 objectives. Right now the objective-setting process for those block grant funds is not terribly rigorous in most of the States, and the amount of tracking of progress in terms of what is actually being accomplished is not very impressive. I think it needs to be much better.

Senator KENNEDY. It would be helpful perhaps if you could in supplementing your testimony, give us some examples of that, you know, at a later time. I think it would be valuable to our consideration of whether we can just continue the way we're going or whether we do establish some criteria, some planning goals following the "Objectives for the Nation" criteria.

Dr. HAVAS. Right now I think the accountability, from what I have seen now, being in two different States involved in that block grant process, is not very good. And there is almost a sense that one could use those funds for almost anything that was related to prevention, and no one would watch terribly carefully to see that in fact one was doing that in a manner that would have a significant impact on public health.

I believe that both the setting of those goals and objectives and the reporting of progress should be required for funding, and certainly if you're thinking about increases in funding. But even at the funding that is there right now, I think that that would be necessary. And I think that it would have to go beyond the kind of reporting that was described earlier, the ASTHO reporting that is done by many of the States. Those data are not what I would call hard data that one could really back up. I think that one really has go to out and monitor either via telephone surveys or household surveys for a lot of this to really track what is being done. And that's not occurring in most of the States right now.

And most of the States, when they do fill out those ASTHO forms, don't do it in a terribly rigorous manner.

Again, I would like to strongly urge you to increase funding for the preventive health and health services block grants so that our State and the country as a whole can move forward in achieving substantial reductions in death and disease rates. Without such funding, our progress toward that goal will be small.

The economics of public health argue strongly for spending more money on prevention. Federal leadership in setting priorities for prevention activities and providing funds to States for accomplishing them are critical. Without this leadership and funding, many people will become sick, and some of them will die needlessly.

Thank you.

[The prepared statement of Dr. Havas follows:]

Testimony to the U.S. Senate Committee on Labor and Human Resources on the Preventive Health and Health Services Block Grant

By: Stephen Havas, M.D., M.P.H., M.S.
Deputy Commissioner
Massachusetts Department of Public Health

Mr. Chairman and distinguished members of the Committee, I am Dr. Stephen Havas. I am the Deputy Commissioner of the Massachusetts Department of Public Health. I appreciate the opportunity to testify before you on the Preventive Health and Health Services Block Grant. My presentation will focus on three areas: 1) the need for increased funding for this block grant; 2) the need for targeting that increased funding towards the goals and objectives set out in Healthy People and 1990 Objectives for the Nation; and 3) the need for tracking progress towards those goals and objectives.

1) Need for increased funding

Funding for the Preventive Health and Health Services Block Grant should be increased substantially. The states have still not recovered from the setbacks that resulted from cuts in funding when it was shifted from a categorical basis to a block grant basis. For example, Massachusetts received 22% less funding in FY'84 than in FY'81. This reduction in funding has resulted in decreased program efforts in all areas covered by this block grant. When inflation is factored in, the cuts since FY'81 are even deeper. This state, like all others, has not been able to rebuild these programs through state funding. Furthermore, the "administrative savings" which were to accrue to the states from block grant funding have not become evident to any of us.

We would recommend an increase of $50 million for Preventive Health and Health Services Block Grant for FY'85. Disease prevention programs are critical investments to preserve and improve the public's health. If preventive services are not adequately funded, the health care costs for treating diseases which could be prevented will far exceed the savings from limiting block grant funding.

2) Targeting of funding

Rather than simply increasing each state's funding under the block grant, the funds should be specifically targeted to address the 15 disease prevention areas outlined in Healthy People and the 1990 Objectives for the Nation. If such targeting is not done, the increased funds are likely to be used in an unstructured manner that minimizes both effectiveness as well as accountability.

For this process to be successful, participating states should be required to prepare comprehensive plans for the use of such funds. In these plans, states should address a minimum of three and a maximum of five out of the 15 disease prevention areas. Few states would be capable of strengthening or initiating efforts in more than five areas at once.

In Massachusetts, we are currently in the planning stages for a statewide multiple risk factor reduction program aimed at the three leading causes of death. We chose this approach because it has the greatest potential impact on mortality and morbidity within the state. Together heart disease, cancer, and stroke cause over 70% of deaths in Massachusetts, as they do nationwide. The majority of deaths from these causes are preventable through a reduction in their underlying risk factors. These risk factors have been well identified and are extremely common in our society. They are also susceptible to reduction. We believe that a program focusing on the prevention of these diseases could very rapidly achieve substantial reductions in mortality rates. However to implement them, we will need funding beyond what is currently available for the block grant.

The impact from disease prevention efforts in these 15 areas can be large. The impact can also be rapidly felt. To cite one example of the success of such efforts, Connecticut conducted a five year demonstration project for high blood pressure control from 1978 to 1983. That effort was funded through a grant from the National Heart, Lung, and Blood Institute.

Within three years of the inception of that project, age-adjusted heart disease mortality rates dropped 11.6% in Connecticut, compared to 5.2% in the United States as a whole. For stroke, the declines in age-adjusted mortality rates were even more impressive - 28.3% in Connecticut compared to 15.5% in the U.S. as a whole. The declines in morbidity continued in the final years of the project, albeit at a slightly slower pace.

3) Monitoring progress in disease prevention

It is extremely important that participating states not only undertake a planning effort but also closely monitor progress in meeting their objectives.

This tracking should focus on changes in risk factors as well as changes in mortality. The states should set quantifiable goals and objectives consistent with the 1990 Objectives for the Nation and monitor on an annual basis their progress towards achieving them. Both the setting of goals and objectives and reporting of progress on them should be required for continued funding.

Closing Statement

Again, I would like to strongly urge you to increase funding for the Preventive Health and Health Services Block Grant so that our state and the country as a whole can move forward in achieving substantial reductions in death and disease rates. Without such funding, our progress towards that goal will be small.

The economics of public health argue powerfully for spending more money on prevention. Federal leadership in setting priorities for prevention activities and providing funds to states for accomplishing them are critical. Without this leadership and funding, many people will become sick and some of them will die needlessly.

Thank you.

Senator **Kennedy**. Maybe you could outline for us, if we did provide additional resources and we did give a greater definition of criteria, what do you think could really be achieved and accomplished in the country over the period of these next several years? Obviously, it depends on the amount of money, I suppose, but what sort of achievements and accomplishments?

Dr. **Havas**. Well, I think the kind of program that I was involved with in Connecticut could easily be replicated on a national basis. But I think unless there is some rigor built into the block grant, it's unlikely to happen in most of the States. Even in Connecticut now, the followup since that period, there has been much less of an effort along the lines of that blood pressure program. And I think part of that is because under the grant from the Heart, Lung and Blood Institute there was a lot more accountability. They were specifically told to do a 5-year demonstration project. They knew that progress was being monitored on blood pressure levels within the State and that mortality rates were being followed very closely.

Under the block grant there is not that kind of close following, and so a lot of the funds often are—the decisions on how to spend them are more a result of political forces than perhaps based on sound public health rationale.

Senator **Kennedy**. Have you reviewed the Surgeon General's recommendations, and do you think that those are sound and useful?

Dr. **Havas**. Absolutely. And I think you don't need great amounts of money to do these kinds of things, but you do need to do them in a comprehensive way. If you look at the prevalence of some of these risk factors, they are very high. Smoking affects about a third of the adult population. High blood pressure—if you define it as 140 over 90 or above—affects about a third of the population. Diets that are high in fat—about 70 percent of the population eats that kind of diet, which increases the risk for both heart disease and cancer.

Physical inactivity—about two-thirds of the adult population would be defined as physically inactive.

So we're talking about things that don't affect just a small number of people, but really a population base. To change that, you need to divide the States into regions, go out and work with business and industry, work with the local communities, that kind of thing, and really go after large numbers of people. But you don't need huge amounts of money. You do need, however, more than is involved here. And I think you really need to say to the States, "These are the kinds of areas we want you to focus on rather than the broad area of prevention," because what you can sneak in under that "broad" label makes it almost meaningless.

Senator **Kennedy**. Good. OK. That is very helpful, and we will be getting back to you as we move toward the legislation.

We want to thank you very much.

Dr. **Havas**. Thank you, Senator.

[Additional material submitted for the record follows:]

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AMERICAN LUNG ASSOCIATION
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S. 2301, The Health Services, Preventive Health Services, and Home and Community Based Services Act of 1984

Statement of the

American Lung Association

Committee on Labor and Human Resources
United States Senate

February 21, 1984

National Headquarters: 1740 Broadway, New York, N.Y. 10019 • James A. Swomley, Managing Director

The American Lung Association welcomes this opportunity to comment on S. 2301, "Health Services, Preventive Health Services, and Home and Community Based Services Act of 1984." The American Lung Association is this nation's oldest voluntary health agency, established in 1904 as the National Association for the Study and Prevention of Tuberculosis. The organization remains committed to its original goal--the eradication of tuberculosis--while expanding its mission to address the greater challenge of the prevention and control of all lung diseases. The primary emphasis in this statement will be justification for reauthorization of the Tuberculosis Control Program for fiscal years 1985, 1986, and 1987. A secondary empahsis will address the continued need by the chronically ill for adequate home health care services.

Tuberculosis Control Program

Tuberculosis is an infectious disease which can be transmitted without regard to geographic or governmental boundaries. It is a public health problem of national scope and its prevention and control require a national commitment.

Due to advances in medical sciences, tuberculosis is preventable and curable when treated with appropriate drugs. The drugs are inexpensive and hospitalization is usually not required. However, drug therapy must be undergone for approximately one year. Generally local health departments have the responsibility for locating individuals with tuberculosis and ensuring that they complete drug therapy. A further responsibility is the identification of persons in contact with individuals diagnosed with TB in order to begin preventive therapy if so indicated.

During the past 25 years, the number of reported TB cases has declined by approximately 4 percent per year. In 1980, however, the rate increased by 0.6 percent, the first such increase since 1963. A major contributing factor for the increase in incidence was the large number of TB cases diagnosed in the Indochinese refugee population migrating to the United States during 1979 and 1980. In 1981 the rate declined 6 percent to 27,373 cases and in 1982 a further decline of 7 percent to 25,522 was noted. This decrease represents the anticipated rate of decline with adequately functioning TB control programs.

Continued funding of the Tuberculosis Control Program will enable the Centers for Disease Control to address several specific proglems which remain in the control and prevention of tuberculosis

- Drug Resistant Tuberculosis is a continuing problem for many health departments. Approximately 7 percent of new cases (previously untreated cases) are found to have been caused by drug resistant tuberculosis bacteria. There have been 3 community outbreaks of drug resistant tuberculosis--Mississippi, New York, and Montana. Therapy for drug resistant TB presents a more complex treatment problem. The drugs used are more toxic and less effective creating patient compliance problems which require a significant increase in the surveillance activities of health department out-reach workers.

- Tuberculosis in Children, which is an indicator of on-going transmission in a community, has shown no decline in the period 1976-1982. Only about 30 percent of children who are contacts to new cases are placed on preventive therapy. This population is considered a primary priority for preventive therapy since they are at highest risk of developing TB. Further, preventive therapy for children does not present the compliance problems of other populations since children do not experience any side effects to the drug therapy. Improved case-finding and improved surveillance and assessment activities by outreach workers could increase the percentage of children (who are contacts to new cases) placed on and completing preventive therapy.

- Examination of Contacts and Completion of Preventive Therapy continues to be a problem. Annually, approximately 10,000 contacts of new cases are not identified. 5 to 10 percent of these contacts can be expected to subsequently develop infectious TB. Over 30 percent of persons placed on preventive therapy fail to complete the recommended regimen--18,000 persons annually. As a result, 900 to 1,800

> of these persons, even though examined and placed on preventive therapy, will eventually develop infectious disease. Improved case-reporting and disease surveillannce and additional out-reach workers who directly observe therapy could accelerate the reduction of transmission of disease from this group and avoid unnecessary hospitalizations.

The continued funding of the Tuberculosis Control Program at the levels authorized in S. 2301 of $8, 9, and 10 million respectively for fiscal years 1985, 1986 and 1987 is essential if we are to achieve a case rate of 9 cases per 100,000 by 1990, a goal identified by an expert Task Force of the ALA in 1982. The prevention and control of tuberculosis can be achieved economically and effectively and it would be a very short-sided policy not to invest in the funds needed for its control. The cost of preventing and controlling tuberculosis falls far below the cost to society of neglecting this important health problem.

The ALA's medical section, the American Thoracic Society and the Centers for Disease Control prepared 3 important publications on the prevention and control of tuberculosis which we would like to enter into the record. The publications, "Treatment of Tuberculosis and Control of Tuberculosis", "Diagnostic Standards and Classification of Tuberculosis", and "The

Tuberculin Skin Test" outline recommendations for treatment of TB, guidelines for preventive therapy and objectives for community TB control programs.

Home Health Care Services

Our remaining remarks will address the provisions in S. 2301 which provide new authority for a home health services and community-based health services block grant. The ALA is dedicated to the identification and delivery of the best possible care for individuals with lung diseases and has taken a leadership role in communicating current knowledge of these diseases and the factors affecting patients suffering from them.

Approximately 16 million Americans suffer from one or more chronic pulmonary diseases including emphysema, chronic bronchitis, and asthma. 45 percent of patients with emphysema report restriction in their daily activities due to disease, 18 percent of patients with asthma reported such restrictions, as did 4 percent of patients with chronic bronchitis.

New knowledge that benefited respiratory patients in the hospital has not been readily accessible to patients in the home. For this, and other reasons, out-of-hospital home health care is in need of review. The general goal of home health care is to promote, maintain, or restore health and minimize the effects of illness and impaired function. The services should be given by agencies meeting appropriate standards, and should help recipients achieve and sustain an optimum level of health, activity, and independence. The services may be therapeutic or preventive. The purpose of home care should be the provision of direct patient services, treatment, education or evaluation.

Health care within the home for both adult and pediatric respiratory patients have been impaired because of many deficits. There is the lack of individuals educated in the specific needs of respiratory patients in the home, lack of adequate home care services, lack of effective coordination of these services, limitations in financial coverage, and regional variability of coverage.

Unique problems arise in the allocation of home health care services for children with chronic pulmonary diseases. Asthma and cystic fibrosis are the major causes of school absenteeism and disability for children under 17 years of age.

For the respiratory disease patient, the home health care team, optimally, should be composed of physicians, both primary care as well as specialists in pulmonary medicine; respiratory nurse specialists and nursing personnel at all levels; psychologists; social service personnel; physical therapists; occupational therapists; respiratory therapists and technicians;

vocational counselors; nutritionists; homemakers; and home health aides.

Direct services may, but need not always, incude such services as physical training, energy conservation measures, bronchial hygiene, breathing exercises, psychological and vocational counseling, nutrition education, equipment management and monitoring, personal care, housekeeping or homemaker services, transportation, meal preparation or provision, financial support or planning and escort service.

Not all home patients need all services, and many needed services are unavailable. Patients' disease processes, for example, may be "stable" but require basic supportive services such as chest therapy. Chronic periods may be marked by exacerbations requiring even more supportive services, such as oxygen, assistance with ambulation, or dietary changes.

The ALA supports efforts to expand home health care services to the disabled and elderly. This population should include respiratory disease patients and of particular importance, the unstable patient with recurrent cardio-pulmonary deterioration. The ALA believes the needs of many patients with chronic respiratory disease could be better met in the comfort of their homes instead of resorting to institutional care. However, the comprehensive needs of of respiratory patients must be met if home health care is to be a viable alternative to institutional care.

To ensure proper care and treatment of patients in the home, standards should be established for health professionals and all personnel providing home health care services. Inclusion of standards should be part of the certification process of all agencies providing home health care services.

Thank you for this opportunity to present our views.

THE NATIONAL HEALTH SERVICE CORPS
AND
HEALTH MANPOWER SHORTAGE AREAS

REAPPRAISAL AND RECOMMENDATIONS

Section 332 [254e](b) of the Public Health Service Act states that

> The Secretary shall establish by regulation... criteria for the designation of areas, population groups, medical facilities, and other public facilities, in the States, as health manpower shortage areas. In establishing such criteria, the Secretary shall take into consideration the following:
> (1) The ratio of available health manpower to the number of individuals in an area or population group, or served by a medical facility or other public facility under consideration for designation.
> (2) Indicators of a need, notwithstanding the supply of health manpower, for health services for the individuals in an area or population group or served by a medical facility or other public facility under consideration for designation, with special consideration to indicators of--
> (A) infant mortality,
> (B) access to health services, and
> (C) health status.
> (3) The percentage of physicians serving an area, population group, medical facility, or other public facility under consideration for designation who are employed by hospitals and who are graduates of foreign medical schools.

The following salient points should be noted regarding the discussion of health manpower in these regulations: (1) health manpower is denoted only in terms of availability; (2) the percentage of local hospital-employed and foreign medical graduate physicians will be taken into consideration -- and their services will, in the main, be determined as unavailable in terms of the provision of primary care; and (3) indicators of an area's or population's need for health services will be taken into consideration "notwithstanding the supply of health manpower" that may be present in the area.

Those indicators of need which will receive special consideration are infant mortality, health status, and access to health services. High infant mortality rates and poor health status have been demonstrated to be closely associated with poverty.[1-3] Moreover, recent studies have shown that low economic status is the single most significant barrier to gaining access to health services.[4-6] Therefore, it would seem evident that the indicator of need that requires the most careful consideration is the economic inaccessibility of personal health services.

There is currently no evidence that the national poverty level will decline during the coming years. Further, the growing production of physician manpower has thus far been accompanied by a trend toward higher medical costs, but not an increase in the availability, much less the economic accessibility, of primary care physician services.[7] Thus, the need to maintain a basic minimum of health services for the poor and near poor will require the continued supplementation of accessible primary care manpower services through such mechanisms as the National Health Service Corps for the foreseeable future.

In light of the above, the following recommendations are offered regarding the designation of Health Manpower Shortage Areas (HMSAs):

- Indication of need (based upon the economic inaccessibility of health services) will be given priority over physician/population ratios in determining area and population designations.

- Areas and populations with poverty levels of 150 percent of the national average or greater will automatically receive designations.
- Primary care physicians will not be included in physician/population ratio computations for designation purposes if (1) their services are provided under contractual or other employment arrangements through federal or other public (i.e., state, local) funds, or if (2) the percentage of their medical practices based on Medicare/Medicaid reimbursements is less than 50 percent of the national/state average for physicians in the same specialty fields.

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ASSOCIATION of SCHOOLS and COLLEGES of OPTOMETRY

Statement of the

Association of Schools and Colleges of Optometry

on

National Health Service Corps Amendments of 1984

S2281

to the

Committee on Labor and Human Resources

United States Senate

Association of Schools
and Colleges of Optometry
600 Maryland Avenue, S.W.
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March 7, 1984

ASSOCIATION of SCHOOLS and COLLEGES of OPTOMETRY

The Association of Schools and Colleges of Optometry represents the 16 optometric education institutions in the United States, graduating some 1100 optometrists annually. We remain committed to improved access and the highest quality of vision services to the people.

Over the years the NHSC has evolved as a significant Federal program to ensure access to health care for the underserved. Other legislation enacted by the Congress has been instrumental in increasing the number of graduates in optometry which has further provided for the vision care needs. Unfortunately there remains a continuing unmet need due to certain geographic and demographic factors which increased competition will not solve. There is, therefore, a continuing requirement for a level of Federal intervention to serve these otherwise underserved population groups. S2281 proposes 150 new scholarships in health professions which will address the most critical of these health care situations.

While undoubtedly vision care needs of the underserved have been recognized, they have not been addressed in the priorities of the NHSC to date. ASCO wishes to bring these critical needs to the attention of the Congress.

Optometry

The optometric profession has had a long history of success in a balanced geographic distribution of its practitioners. More recently the increasing indebtedness of new optometric graduates and the evolution of specialized practice of the profession have resulted in a shift to this pattern. More of the graduates now find it necessary to locate in high density, affluent population centers rather than the more rural communities. Additionally, the social and economic deterioration of some major inner city areas have resulted in migration of optometrists to suburbia. These circumstances and a general shortage of primary vision care providers have resulted in a number of areas being classified as Vision Care Shortage Areas under the health manpower shortage area criteria of the Public Health Service and an additional number of counties considered as eligible to be so declared.

The schools and colleges of optometry have responded in part to this shortage, having increased the graduates of U.S. schools from 789 in 1975 to 1106 in 1983. This 40% increase has increased competition and benefited geographic distribution. The American Optometric Association through an Urban Optometry Project is working to assist inner city optometric practices to survive.

It is our opinion that regardless of these efforts many other factors will still result in a certain number of areas which will not attract a qualified vision care practitioner. The assignment of an optometrist through the NHSC is considered necessary to bring adequate primary vision care to the most critical of underserved groups.

To date vision care needs have received only minimal attention by the NHSC. Based on appropriations language in 1979 a few scholarships were awarded. We appear today to request your support under S2281 for an amendment to provide for addressing critical vision care manpower needs. This amendment to 338F(a) would be to allocate 10% of the new scholarship awards to students in schools and colleges of optometry.

As of the latest listing in the Federal Register the Public Health Service had designated over 250 counties as vision care shortage areas (1981). Little has been done in recent years to collect the necessary data to request designation of other areas since no solution to this critical problem was at hand. The Congress has the opportunity with these amendments to the NHSC to contribute to the vision well being of underserved populations in our country.

NC
EMS

NATIONAL COALITION FOR EMERGENCY MEDICAL SERVICES
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March 6, 1984

Committee on Labor and Human Resources
United States Senate
Washington, D. C. 20510

Mr. Chairman and Members of the Committee:

The National Coalition for Emergency Medical Services, Inc. (NCEMS) would like to express its position regarding federal support for emergency medical services. The NCEMS represents a wide variety of emergency medical service providers including physicians, nurses, paramedics, and ambulance drivers among others. As such, we are experienced in working with crisis situations -- situations that are literally a meaning of life and death for the victims of trauma. Ironically, the emergency medical services system finds itself on the brink of a crisis. Despite the fact that tremendous strides have been made in EMS, further development is jeopardized by lack of adequate funding.

The reality of serious accidents occasioning the need for immediate specialized medical attention is all too apparent. Every year over 10,000,000 persons are victims of trauma. Some 350,000 of these suffer permanent disability, and over 100,000 people die from traumatic injuries on an annual basis. It is the third greatest killer in the United States and the number one killer of people under the age of 40. We can reasonably conclude that each person in this country will need the services provided by an emergency medical system some time during his or her lifetime. The questions are: Will it be there? Will it be adequate?

A comprehensive system of emergency medical services is extremely effective in reducing the number of deaths and serious injury complications resulting from trauma. When an EMS system is in place and operating, the chance of a victim being saved is 85%; without a system, this drops to 60%. In the State of Maryland, where a statewide EMS system has been in place for ten years, the mortality rate has fallen from 78% to 14%.

The purpose of emergency medical services systems is to transform the victims of trauma into patients, by providing a means of prompt rescue, knowledgeable treatment at the scene of the accident, and the transportation to a definitive medical facility. When a system is in place, a victim is treated at the scene of the accident by a trained emergency medical technician or paramedic who is capable of performing basic, and when appropriate, advanced life support care. He can analyze the victim and, if needed, receive instructions from a physician at a medical command station situated in a trauma center.

Time is critical; a victim treated by an EMS team will receive initial care and be in the definitive medical center within 60 minutes.

Mr. Chairman and Members of the Committee, we have come a long way. In the years of federal support for the EMS initiative, the highest standards of care have been defined and implemented. Transportation and communications equipment and networks have been tailored to meet the specialized needs of the quick response team providing emergency medical services. Paramedics and emergency medical technicians who man the ambulances and helicoptors, and who begin treatment, are trained in life support techniques which meet national standards. Trauma centers provide physicans, surgeons, and other specialists when the patient arrives.

Nevertheless, we are only on the threshold of realizing the full potential of the EMS concept. New comprehensive EMS systems must be established to fill the voids in the national networks. Existing systems must be updated and expanded if necessary.

Emergency medical services needs special attention -- by the federal government, as well as the state and local governments. In recent years, under the preventive health services block grant, EMS has received a fraction of the dollars needed when compared to the magnitude of the problem it addresses. Present funding levels are inadequate to provide for the growth and expansion necessary to bring the EMS system to its true optimum. The problem it addresses is national in scope and interstate in services rendered. We believe that provision of emergency medical services is, therefore, of sufficient federal concern to warrant special consideration either through separate authorization as a categorical program or special earmarking in the preventive health services block grant.

The National Coalition for Emergency Medical Services appreciates this opportunity to comment. If we can provide any additional information, please do not hesitate to contact me.

Sincerely,

Harry Teter

Harry Teter, Jr.
Executive Director

HTjr:a

PREVENTION NOTES

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS Telephone (703) 556-9222

A NEWSLETTER ON STATE USE OF THE PREVENTION BLOCK GRANT ISSUE 1

SICKNESS CARE
PREVENTION

The most cost effective expenditure in the Federal health care budget is for preventive health care. Preventive health care services eliminate and significantly reduce incalculable human suffering, the number of days lost from work or school, and they help people feel good about themselves. Disease prevention, risk reduction, health education and improved lifestyle, proper nutrition, exercise and physical fitness, early detection of disease — that's what the Preventive Health and Health Services Block Grant is all about. State and local health departments have a lot to say about the innovative uses of the block grants and *Prevention Notes* has been initiated by state health officials to tell the story.

Expenditures for medical care have continued to rise annually but the Federal spending for prevention and basic public health programs has remained relatively constant since 1970 at approximately $90 million. State health officials urge that at least 50¢ per capita be devoted to prevention — that the authorization and appropriation for Preventive Health be increased to a minimum of $115 million. *Prevention Notes* will tell why.

Health Risk Assessment

Health risk assessment/health hazard appraisal (HRA/HHA) is a component of "prospective medicine," with emphasis on identifying precursors of illness and injury and controlling them. HRA/HHA programs in use nationally range widely in terms of scientific basis, sophistication and comprehensiveness.

Dr. Lewis C. Robbins, Chief of the Cancer Control Branch of the Division of Chronic Diseases of the United States Public Health Service, founded "prospective medicine" in 1959. Up to that time, the prevailing philosophy of cancer control was based on early detection and treatment. Dr. Robbins believed that, while early diagnosis and treatment are important, cancer could be more effectively controlled through a program of identifying and reducing causes of the disease. Thus was introduced the concept of recognizing and quantifying health risks and reducing or controlling the causes of disease; over time it was extended to injuries and diseases other than cancer.

The following exemplifies how risk factors contribute to causing disease:

- A two-pack-a-day smoking habit doubles the average risk of dying from lung cancer for a 45-year-old individual. If the individual quits smoking, the risk of death from lung cancer returns to average after a 10-15 year period.
- Using seat belts reduces the danger of death and injury from motor vehicle accidents by 60 percent.
- A 50-year old man with uncontrolled high blood pressure has twice the chance of suffering a heart attack as an individual with normal blood

> pressure. If that person smokes or has a high cholesterol diet, his chances of suffering a heart attack are 8 times higher. If all three risk factors are present in that individual, his chances of heart attack are 12 times greater.

The nation's first public health revolution, characterized by the control of communicable diseases, has proved highly successful. Today the nation is embarked on a second public health revolution directed at chronic disease, the major cause of disability and death in the U.S. In this war on disease, a health lifestyle emerges as a most important weapon, and the HRA/HHA program as an attractive health promotion technique.

The health hazard appraisal has its critics, mainly alleging that scientific evidence is insufficient to document its effectiveness.[1] On the other hand, the Director of the Centers for Disease Control has written:[2]

- "HRA/HHA should not be construed as a panacea to handle the complex medical, environmental, and behavioral problems related to chronic diseases and trauma. Behavioral change results, while important, should not be the only criterion by which HRA effectiveness is judged. Perhaps its greatest value is to clarify the immense complexities of biomedical and epidemiological research and present them in a format that is both understandable and relevant to the individual citizen."

In their book, PROSPECTIVE MEDICINE,[3] Hall and Zwemer made this observation:

> "Finally, health hazard appraisal has been shown to stimulate favorable changes in health behavior — particularly in such areas as alcohol habits, body weight, breast self-examination, exercise and seat belt usage."

SPECIFIC OBJECTIVES FOR THE 1990's (As stated in *Promoting Health/Preventing Disease for the Nation)*:

a. By 1990, at least 60 percent of the estimated population having definite high blood pressure (160/95) should have attained successful long-term blood pressure control (140/90 or below).

b. By 1990, the prevalence of significant overweight (120 percent of "desired weight") among the U.S. adult population should be decreased from 10 percent of men and 17 percent of women without nutritional impairment. (In 1971-74, 14 percent of adult men and 24 percent of women were significantly overweight.)

c. By 1990, the proportion of adults who smoke should be reduced to below 25 percent. (In 1979, the figure was 33 percent.)

d. By 1990, the proportion of problem drinkers among all adults aged 18 and over should be reduced to 8 percent. (In 1979, it was about 10 percent.)

e. By 1990, the proportion of adults 18 to 65 participating regularly in vigorous physical exercise should be greater than 60 percent. (In 1978, the figure was over 35%.)

Current Activity:

In general, HRA/HHA programs administered by the nation's health departments are not lengthy, comprehensive or sophisticated, nor do they place heavy emphasis on morbidity/mortality data, quantification of risks or prediction of death. Their primary purpose is to raise the level of awareness regarding the linkage of behavior to disease and death and to encourage the adoption of more healthy lifestyles.

Centers for Disease Control. According to a 1982 survey,[4] 22 state and territorial health departments are now using health risk appraisal forms developed by the Centers for Disease Control. The remaining states and territories are planning to use health risk appraisal programs in the future according to the survey.

Rhode Island. The Rhode Island Department of Health has developed Wellness Check, a computerized health risk appraisal program. Wellness Check clients complete a questionnaire card concerning their lifestyle habits; their responses are fed into a card reader linked to a microcomputer; immediately they receive a personalized printout rating their health status, detailing the health risks, and recommending interventions. There are both adult and teenage versions.

In Rhode Island, most of the Wellness Check participants have been processed through the "Wellness Wagon", a computer equipped van that has traveled throughout the state. The system provides for immediate comparison of lifestyle profiles among various participating groups, schools, businesses or communities. Program software and materials are being provided to every high school in the state to facilitate customizing health education programs for each school system to meet particular community needs.

Arizona. The Arizona Department of Health Services is conducting two local community health promotion projects, in an urban and a rural site. The program is neighborhood based and focuses on encouraging individuals to accept more responsibility for their own health, the health of their family and their community.

Layleaders in each site were selected to serve on a Health Council which is responsible for planning and implementing the health promotion activities in the community. Involvement of area businesses, health facilities, civic groups and organizations and professionals in each community assures community integration of the project. Among the activities being conducted are: CPR and basic first aid training, home safety assessment, establishment of a neighborhood health resource center, health risk appraisal and lifestyle counseling, health fairs and senior needs assessment.

New Jersey. The Lifestyle Improvement for Employees Project (LIFE), developed by the New Jersey Department of Health, is responsible for organizing employee intervention programs for smoking, exercise, weight control, nutrition and stress in the State Department of Health. LIFE also provides assistance to other State agencies (Education, Higher Education, Treasury) in establishing similar employee health promotion activities. Ten additional State agencies have expressed interest in LIFE.

Oklahoma. In Oklahoma businesses and industries have eagerly participated in the Oklahoma State Department of Health's Lifestyle seminars, health hazard appraisals and blood pressure screenings. Several companies saw a 90 percent participation rate in the prevention programs. Other companies, including Ingersoll Rand and C. R. Anthony, used the lifestyle seminar and health hazard appraisal as the kick-off event for their own "brown bag" health seminars. Diamond Crystal Salt Company and Goodyear Tire Company were among businesses that were so impressed with the need for healthy lifestyles after participation in this program, that they developed exercise programs for their employees and now provide incentives to stop smoking and lose weight.

Connecticut. In Connecticut the State Health Department uses health education methods to reduce four risk factors: smoking, excess dietary fats and sodium, physical inactivity, and high blood pressure. Through these statewide efforts conducted by the Department as well as grants to local agencies, Connecticut has noted the following achievements:

- The number of public high schools in the state permitting student smoking areas has declined for the first time in 10 years. The Department is forming coalitions with the state's three major voluntary health agencies to persuade more local school boards to rescind student smoking privileges.
- Approximately ⅓ to ½ of those served by local grants were at risk for one or more of the four factors. Evaluation measures collected at the beginning of programs by six local projects for clients served indicated that: 35% smoked; 36% consumed excess sodium and fat; 47% did not exercise on a regular basis; 30.7% had borderline or elevated blood pressure and 22.8% were not aware of the blood pressure status.
- Over 100 Fair Haven senior citizens were taught to reduce sodium and fat in their traditional ethnic holiday recipes by a local grant-funded nutritionist. The area served is a part of New Haven which is poor and medically underserved and over 50% of the seniors had high blood pressure or heart disease.

Analysis:

The battle for improved health behavior is being won. Fewer people are smoking cigarettes, more are exercising, more have their high blood pressure under control, more are eating healthier diets, and more are wearing seat belts. Although much has been accomplished, so much more can be done with additional resources. Increased funding will allow states the flexibility to undertake different intervention strategies, document the effect of these strategies, expand target populations and bolster program efforts aimed at early intervention.

Block Grant Impact:

The Preventive Health and Health Services Block Grant of $88.2 million inadequately supports this effective tool for health promotion and disease prevention. The appropriation for 1985 should be increased to at least $115 million. The per capita cost for health care in the United States is $1400. Surely, the nation can pay $.50 per capita to prevent illness and injury.

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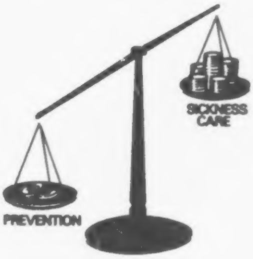

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TESTIMONY

OF THE

AMERICAN ACADEMY OF PEDIATRICS

SUBMITTED TO THE

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

ON

S. 2301

HEALTH SERVICES, PREVENTIVE HEALTH SERVICES AND HOME AND COMMUNITY-BASED SERVICES ACT OF 1984

MARCH 7, 1984

Office of Government Liaison
1300 North 17th Street
Arlington, Virginia 22209
703-525-9560/800-336-5475

The American Academy of Pediatrics is pleased to submit comments on S. 2301, the "Health Services, Preventive Health Services, and Home and Community-Based Services Act of 1984." We will confine our remarks to those sections of the bill which deal with the reauthorization of the childhood immunization program and with improved emergency medical services for children.

One of the best examples of an effective preventive measure is childhood immunization. It is one program which experts accept as a safe and cost-effective expenditure. Immunization against seven childhood diseases -- diphtheria, pertussis, tetanus, measles, rubella, mumps and polio -- has been responsible for a reduction in childhood mortality and the handicapping conditions which can result from these diseases. The 3 million children born each year must be immunized against these diseases; each failure becomes a potential victim for the future. (See Appendix I.)

In the mid-1960s it became evident that immunizations could play an important role in child health. In 1966 the federal government began to fund measles and polio immunization programs through grants to states. In 1977 the federal government launched a major drive, the Childhood Immunization Initiative. This program provided matching grants to states to 1) purchase vaccine; 2) inform parents of the need for immunization; and 3) assess the number of children protected. This highly successful program was greatly responsible for raising the immunization levels of kindergarten and first-grade children to more than 95 percent in 1983.

The rising financial cost of these programs, both federal and state, must be met. The failure to provide adequate funding means significant cuts in services. The Center for Disease Control and other public health experts warn that within one year after relaxing immunization programs, the rise of reported cases of measles, rubella, polio, diphtheria, pertussis and tetanus would result in needless tragedy. (See Appendix II.)

No one can quantify the pain associated with these illnesses. Deafness, blindness, cerebral palsy, retardation and severe emotional disturbances can destroy children and their families. When the capacity to prevent these conditions is at hand, failure to protect our citizens is doubly cruel. The authorization levels provided in S. 2301 are insufficient to meet these needs. These levels, at a minimum, should reflect the FY 1983 funding level of $39 million, the FY 1984 funding level of $42 million and the President's request for a fiscal 1985 budget of $46 million, and be adjusted accordingly through the fiscal year ending September 30, 1987.

We direct the Committee's attention to three major issues which should be considered in developing the authorization levels for the fiscal years 1985-88.

1. The Administration has requested an additional $2 million to initiate a campaign to eliminate rubella in its fiscal 1985 budget request. We would support this initiative. Babies born with rubella syndrome suffer needlessly from severe defects of the brain, eyes and heart. We would urge the Committee to make the necessary legislative modifications in current law to allow for the immunization of women at risk.

2. While vaccine costs have increased significantly over the recent years, the cost of the DPT vaccine has increased dramatically. CDC

currently does not purchase this vaccine under its consolidated contract buying policies for polio and measles, mumps and rubella vaccines, hence these costs are not reflected in the budget. States are currently being saddled with an economic burden that could seriously threaten our successful immunization program. CDC's ability to buy vaccines in bulk has significantly reduced costs to the states, and some attention must be directed to assist states in the economical purchase of the DPT vaccine.

We would urge that the Committee include in its fiscal 1985 budget adequate funds for the inclusion of DPT under the consolidated contract provisions.

3. Of utmost importance is the need for funding to assist the few children each year who suffer adversely from their participation in the immunization program that is required by all 50 states for school entry. We must accept the fact that in individual instances there have been, and will continue to be for the foreseeable future, tragedies that result from the use of the vaccines currently available. We would hope and expect that continued research and developments of improved vaccines will remove some, if not all, of these risks. But that day is not at hand. Until these risks can be removed, the greatest good for the entire population will have to be served by the continuation of the vigorous immunization program now in effect.

Society is the beneficiary of our compulsory immunization laws. Yet when the small percentage of serious injuries inevitably occurs, we abandon those children to the slow, tedious and uncertain tort process for appropriate compensation. Under the present system parents are forced to re-visit over an extended period of time the tragedy that has occurred with their child, and relive a very difficult, emotional crisis.

Since 1977 it has been the Academy's stated policy that children who are injured in the process of complying with mandated immunizations should have adequate compensation provided by the public without the necessity of pursuing their claims in court. The tort process, as aforementioned, is slow, expensive, and uncertain, while the needs of the children are expensive and immediate. This is not a new idea. Some form of such process exists, and has existed for years, in most West European countries and in Japan.

Legislation is currently pending before this Committee, S. 2117, which addresses these issues in detail. We would urge that at this time the Committee, in its report language on S. 2301, acknowledge the need to develop such a system for the United States and make provisions to incorporate such costs at the appropriate time.

With respect to emergency medical services for children, the Academy strongly supports efforts to amend national EMS programs to ensure that special priority will be given to the development of demonstration projects addressing the many unique needs of our nation's children. There is no question that emergency medical service programs have demonstrated their extraordinary cost effectiveness to date; however, statistics suggest that insufficient attention has been placed on the needs of children and youth. For example, of all patients receiving care in our nation's hospital emergency departments, 20 to 35 percent are children or adolescents. Further, on weekends and especially at night, children may account for more than 40 percent of all visits.

Nearly 18 million children receive emergency medical services annually. Unfortunately, statistics indicate that almost 100,000 children are permanently crippled by trauma each year and as much as 55 percent of all deaths up to the age of 15 are due to injuries. Children have unique physical and psychological needs; they are not simply "miniature adults." Special pediatric experience and technology are absolutely mandatory. Yet emergency services remain primarily adult-oriented, even though pediatric emergencies are largely medical rather than surgical and include poisoning, infectious disease, respiratory difficulty and dehydration, all potentially life-threatening.

It is vitally important that EMS for children be made more appropriate and of the highest caliber. Since these services must be precise, and since they vary from the type of treatment offered adults, individuals who provide such care must be properly trained. This cannot be done on a catch-as-catch-can basis. In any given geographical area, there may be relatively fewer numbers of children to be treated. For this reason, it is imperative that their care be regionalized, with the availability of an excellent transport system, so that they can be brought to persons with appropriate expertise and to facilities geared to provide expert care. A more haphazard approach only leads to long-term disabilities or deaths of children, an expensive price for society to bear by any definition. The provision of quality emergency medical services would avert untold numbers of such tragedies.

Thank you for your consideration.

Many Pre-School Children* Still Do Not Receive Vaccinations for Diphtheria-Tetanus-Pertussis, Polio, Measles, Mumps, and Rubella.

Percent of Children Ages 1-4 Not Immunized, 1981

Vaccine	Percent Not Immunized
DTP (3+ doses)	13.1
Polio (3+ doses)	21.7
Measles	24.4
Rubella	24.8
Mumps	27.3

* N.B. Due to school immunization requirements, the percentage of U.S. children with these immunizations increases to between 94 percent and 96 percent after school attendance begins.

SOURCE: Based on immunization records as source of information. 17th Immunization Conference Proceedings, May 18-19, 1982, Atlanta. U.S. Immunization Survey, 1981, Table 13, p. 54.

Immunizations Have Demonstrated Their Cost-Effectiveness.

Measles: The net benefits nationally for measles immunization are estimated to be $1.3 billion for the period 1963-1972.

- Medical savings included 1.4 million hospital days and more than 12 million physician visits.
- 7,900 cases of mental retardation averted as well as premature death.
- 10,300 more persons would have the opportunity to lead productive lives measurable at 709,000 years.
- For every dollar spent on measles vaccination, $10 was saved.

Mumps:

- Of 1 million persons, mumps vaccine would prevent more than 74,000 cases of mumps and 3 deaths.
- Comparing vaccination benefits over a 30-year period with the costs of mumps (with no vaccine program) shows that the costs would be reduced by more than 86 percent — $846,827 versus $6,271,764 for each one million children, resulting in a net benefit of $5,424,937.
- For every dollar spent on mumps vaccine, $7.40 was saved.

Sources: Witte and Axnich, 1975
Wiederman and Ambrosch, 1979

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Statement of the

Federation of Associations of Schools of the Health Professions

on

National Health Service Corps Amendments of 1984

(S2281)

to the

Committee on Labor and Human Resources

United States Senate

FASHP
c/o Mr. Lee W. Smith
Executive Director
Association of Schools and
Colleges of Optometry
(202)484-9406

March 7, 1984

March 7, 1984

Statement of the
Federation of Associations of Schools of the Health Professions
on the
National Health Service Corps Amendments of 1984 (S2281)

The member professions of the Federation of Associations of Schools of the Health Professions are pleased to support the intent and purposes of S2281-"National Health Service Corps Amendments of 1984." The NHSC has contributed significantly to the more appropriate geographic distribution of primary health care providers and the provision of services to underserved populations in the country.

It is true that the increased number of graduates of the health professions schools which have resulted from the health professions education legislation enacted by the Congress have reduced to some extent the need for NHSC. However, as indicated in the remarks introducing S2281, no amount of increased competition will meet the needs of isolated rural areas and the inner city underserved. We also perceive continuing difficulty in meeting the heath care needs in institutionalized circumstances such as prisons, mental health facilities and the like.

In addition to the unmet medical, nursing and dental services of underserved populations we wish to bring to your attention the equally serious unmet optometric and podiatric care needs of the population. To date these have been ill addressed by the NHSC but contribute significantly to the well being of the populace and to their economic productivity as well.

We support the modest level of maintenance of the NHSC provided by S2281 to meet the most critical underserved needs and encourage the Congress to ensure that other health professions receive equitable attention to address the total wellbeing and health status of the population.

We are particularly pleased with the personnel plan report proposed under Section 6 of S2281. The health professions schools associations are supportive of this aspect of the legislation and desirous of participating as appropriate in studies necessary to meet the intent. Such a report should provide the Congress with data necessary for decisions on this important program in the future.

S2281 if enacted will contribute appropriately to the health care needs of the most critical underserved segments of our society.

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TESTIMONY OF THE
AMERICAN MEDICAL STUDENT ASSOCIATION

ON

THE NATIONAL HEALTH SERVICE CORPS AMENDMENTS OF 1984
(S. 2281)

The American Medical Student Association (AMSA) is a national organization of over 25,000 allopathic and osteopathic medical students at 140 schools throughout the United States. We are a completely independent organization of physicians-in-training committed to improving medical education and health care delivery so that we, as future physicians, may better meet the health care needs of all the nation's people. We appreciate this opportunity to share with the Committee our views on S.2281, the National Health Service Corps Amendments of 1984. AMSA has long been an outspoken advocate of the National Health Service Corps as an important, innovative mechanism for assuring access to quality health care services to those Americans in isolated, underserved areas who otherwise could not obtain them, since the program's establishment in 1970. Today, given the increasing overall physician availability throughout the nation, the future size of the NHSC must, at this time, undergo careful scrutiny.

Size of NHSC Should be Adequate to Meet Projected Needs

The National Health Service Corps was developed in 1970; in that year, there were 136.5 active physicians per 100,000 persons in the U.S.[1] It was noted, at that time, however, that there were only 48 physicians per 100,000 population in non-metropolitan counties with populations under 10,000 persons.[2] Since 1970, the total number of U.S. physicians has grown significantly from 281,344 to 409,460 in 1980[1] (Table 1). Likewise, the physician to population ratio has also seen dramatic increases for all U.S. county classifications except those smallest counties with populations under 10,000 persons (Table 2).[2] The most

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Submitted to the U.S. Senate Committee on Labor and Human Resources.
February 23, 1984.

recent data reflects a physician availability in these locales of only 50 per 100,000 population, while the nation overall enjoys a physician to population ratio of 181.4 per 100,000 population.[1] Several excellent studies have reported on the growing diffusion of physicians from the now saturated (non inner city) urban and suburban areas to these small communities.[3,4] The most recent, and probably most complete, is the Administration's report, Diffusion and the Changing Geographic Distribution of Primary Care Physicians.[2] On the basis of very sophisticated models, this report projects unmet need for primary care physicians in priority Health Manpower Shortage Areas (HMSA) through 1994. (Please see Table 3.) Taking into account the projected effects of diffusion, this report estimates a continued unmet need through 1994 of greater than 1,150 physicians.[5]

Currently, the NHSC has 2,800 individuals on duty in HMSA's, approximately 1,900 as federally salaried employees and 900 as private practitioners (PPO).[6] An additional 1,859 physicians is needed, between now and the end of 1985, to meet the entire need in priority HMSA's.[5] The NHSC projects an output of 3,270 NHSC scholarship obligated physicians eligible to begin service payback between now and 1985.[6] We believe, therefore, that the Federal government is in a unique position in the next two years of placing enough physicians to meet the pressing needs of Americans living in critically underserved areas. Yet, many of the neediest HMSA's cannot support a private practice. Consequently, an NHSC field strength cap of 2,100 federally salaried personnel, as proposed in S.2281, would make it unlikely that the NHSC could properly utilize their obligated personnel to meet the needs in these critical areas.

AMSA BELIEVES THAT THE FEDERAL GOVERNMENT WAS WISE TO OBLIGATE PHYSICIANS FOR AMERICA'S UNDERSERVED. DO NOT WASTE THIS INVESTMENT OF UP TO $40,000 PER MEDICAL STUDENT.[6a] FUND THE NHSC FIELD PROGRAM FOR A FIELD STRENGTH OF 1,900 (current NHSC federal salaried)
+1,860 (unmet need in priority HMSAs)
3,760 (total required field strength)
TO ASSURE THAT THESE OBLIGATED PHYSICIANS CAN BE USED WHERE THEY ARE NEEDED MOST.

Small NHSC Scholarship Program

There is reason to expect that, in the foreseeable future, there will be a small number of U.S. communities that, irrespective of the market forces assuring physician availability in most areas, will continue to have problems retaining a physician on a long term basis. These are the areas that, because of their geographic isolation and often destitute social and cultural environment, have difficulties attracting any except the hardiest and most altruistic of those in the helping professions. For this reason, AMSA strongly supports the provisions of S.2281 for the continuation of a small NHSC scholarship program as a source of obligated physicians to serve in such areas. We would, however, like to make several suggestions, given our long association with the NHSC scholarship program and our familiarity with the current system of medical education, about the structure of such a program.

1. Selection of NHSC Scholarship Recipients - We believe that in limiting the NHSC scholarship program to 150 a year, the NHSC has a unique opportunity to attract an elite group of the nation's most committed future physicians-- individuals who are flexible, adventuresome, but most of all dedicated to bringing quality health care services to those among our population who need it most. The identification of such committed health professions students, however, is not an easy task. AMSA believes that the current mutiple choice computerized application used by the NHSC scholarship program for selection of scholarship recipients is unable to assess those personal characteristics most desirable in such practitioners. The additional expense of personal interviews, review of essays on personal qualifications and letters of recommendation are essential if the NHSC is to identify health professions students who most share the goals of the Corps.

   AMSA BELIEVES THAT THE NHSC SCHOLARSHIP PROGRAM MUST GUARD ITS STATUS AS A SERVICE-ORIENTED PROGRAM, RATHER THAN SIMPLY ANOTHER FINANCIAL AID PROGRAM, BY CAREFUL SELECTION OF SCHOLARSHIP RECIPIENTS WHO SHARE THE IDEALS OF THE NHSC.

2. Preparation of NHSC Physicians - Experience has shown that the largest number of NHSC scholarship recipients come from privte medical schools.[7] The community oriented career aspirations of many such individuals attests to the excellent potential that carefully selected students--be they from

private or public schools--have for making fine NHSC physicians. Nonetheless, the medical education received in most private medical schools (as well as a good number of public schools) is based in urban tertiary care centers quite different from the practice setting an NHSC physician would encounter in most critical shortage areas. Moreover, while the type of medical practice promoted in most schools is oriented toward the diagnosis and treatment of complex diseases in a highly technological medical environment, a community medicine approach more oriented toward patient education, health risk assessment and disease prevention is most appropriate for a responsive shortage area practice. AMSA BELIEVES THAT THE NHSC MUST PREPARE NHSC SCHOLARSHIP RECIPIENTS TO MEET THE SPECIAL NEEDS OF THE COMMUNITIES THEY HAVE BEEN RECRUITED TO SERVE. We believe that a series of required educational experiences for NHSC scholars to take place throughout their medical school years to complement their school-based training is essential to ensure that these individuals can deliver the type of health care that is needed in underserved areas. Such required educational programs could take the form of summer courses in community medicine, clinical experiences in shortage areas, and regular communication from the NHSC. Such a requirement would be consistent, for example, with the Armed Forces Health Professions approach to recruiting and training health personnel. In these programs, in addition to financial support, students receive basic training and introduction to military medicine during the course of medical school.

3. Residency Deferral - AMSA has long supported the 1976 provisions limiting NHSC residency deferrals to primary care specialties. Such well trained generalists (family physicians, pediatricians and general internists) were, at that time, a rarity in underserved areas. Today, we believe the complexity of medical care and the nature of undergraduate medical education make residency training an essential component in the education of competent generalists.

   Moreover, it has been postulated that one of the reasons for the dramatic increase in the NHSC retention rate in its early years from 1-3% in 1972 and 1973 to 25% in 1974 was the new policy of recruiting physicians who had completed residency training prior to NHSC service.[13] Prior to that time, virtually all physicians left their NHSC sites after their required tour of duty to complete their training. Today, more than 99% of physicians pursue residency training.[9] Removing the option of service deferral for residency training would drastically reduce the NHSC's ability to retain physicians on a long term basis in underserved areas.

AMSA BELIEVES, THEREFORE, THAT THE RESIDENCY DEFERRAL OPTION FOR NHSC SCHOLARS SHOULD NOT BE DISCARDED.

NHSC Loan Repayment Program

AMSA has been gratified by the continuation of the NHSC Scholarship Program, albeit at low levels, for the last three years (FY 81, FY 82, FY 83). Nonetheless, we have reason to believe that the number of these obligated health professionals will be inadequate to meet the pressing needs in shortage areas in the late 1980's. We believe that a Loan Repayment Program should be established for the Secretary to use at his discretion to recruit additional manpower as needed to staff the NHSC field program in these and future years. AMSA believes that altruistic medical students, whose primary care plans could suffer due to massive educational indebtedness, will be increasingly responsive to loan repayment incentives for practice in underserved areas. While we are aware that the loan forgiveness provisions in the health professions legislation of the past were rarely utilized,[10] AMSA believes that the dramatic increase in the cost of medical education (Table 4) has made such options much more attractive to today's medical students. There are several advantages to supplementing a small scholarship-obligated group with a loan repayment program as needed:

1. Scholarship recipients are obligated and prepared and can be deployed in the least desirable settings with the most pressing needs.

2. Loan repayment can be offered to health professionals near the end of their training to meet specific additional needs (e.g., five pediatricians needed to go to the rural southeast). Such "targeting" of resources to specific needs is cost effective and doesn't require difficult projections about needs many years into the future.

3. This approach saves the administrative cost and uncertainty of a 7-8 year scholarship "pipeline", for all but a small number of critically needed personnel.

The average cost of medical education at private medical schools is currently $19,600 a year.[11] At public schools, it is up to $10,369 for state residents and $13,991 for out of state students.[11] To most effectively offer loan repayment as a financial incentive to medical students incurring these high costs, AMSA believes that such a program should contain the following provisions:

- up to $20,000 loan forgiveness for each year of service performed (based on the actual costs at the school attended)

- loan repayment should apply for all sources of educational loans students have (GSL, NDSL, HPSL and HEAL federal programs as well as state, medical society and other appropriate sources)

AMSA BELIEVES THAT THE NHSC SHOULD ESTABLISH A LOAN REPAYMENT PROGRAM WITH THE ABOVE PROVISIONS TO SUPPLEMENT NHSC FIELD STRENGTH AS REQUIRED IN THE FUTURE.

Conclusion

1) NHSC Size

AMSA BELIEVES THAT GIVEN PROJECTIONS OF NEED IN HMSA'S, NHSC FIELD STRENGTH SHOULD BE ALLOWED TO GROW TO 3,760. A field strength ceiling of 2,100 will not ensure the highest return on large investments made in scholarship recipients.

2) Scholarship Program

AMSA believes that a small scholarship program is warranted to meet continuing needs in severely needy areas. We believe proper care should go into the selection and preparation of this important group of health professionals. We believe that the residency deferral must be be retained to insure that these individuals can give high quality care and to promote the likelihood of long term retention in HMSA's.

3) Loan Repayment

AMSA believes that the NHSC should establish a loan repayment program to supplement the NHSC field strength to meet specific identified needs as they appear in the future.

Thank you for this opportunity to share our views with you. We look forward to working with you in the future.

Table 1

TOTAL AND ACTIVE PHYSICIANS (M.D.'S) AND PHYSICIAN-TO-POPULATION RATIOS: DECEMBER 31, SELECTED YEARS 1950-1978, AND ADJUSTED DATA FOR 1975 THROUGH 1980

Year	Number of physicians 1/		Total population (thousands) 2/	Physicians per 100,000 population		Active non-Federal physicians	Civilian population (thousands) 3/	Active non-Federal physicians per 100,000 civilian population
	Total	Active		Total	Active			
1950	219,997	208,997	156,024	141.0	134.0	193,900	153,640	126.2
1955	241,711	228,553	169,959	142.2	134.5	213,000	167,043	127.5
1960	260,484	247,257	184,896	140.9	133.7	230,200	182,351	126.2
1965	292,088	277,575	198,357	147.3	139.9	254,761	195,451	130.3
1970	334,028	310,845	209,096	159.7	148.7	281,344	206,129	136.5
1975	393,742	340,280	217,966	180.6	156.1	312,089	215,828	144.6
1976	409,446	348,443	219,648	186.4	158.6	320,865	217,515	147.5
1977	421,278	363,619	221,419	190.3	164.2	343,693	219,300	156.7
1978	437,486	375,811	223,274	195.9	168.3	355,569	221,275	160.7
1975 4/	393,742	363,290	217,966	180.6	166.7	335,100	215,828	155.3
1976 4/	409,446	377,320	219,648	186.4	171.8	349,740	217,515	160.8
1977 4/	421,278	391,180	221,419	190.3	176.7	371,250	219,300	169.3
1978 4/	437,486	403,820	223,274	195.9	180.9	333,580	221,275	173.3
1979 4,5/	450,800	416,680	225,099	200.3	185.1	396,680	223,012	177.9
1980 4,5/	460,500	429,800	227,911	202.1	188.6	409,460	225,766	181.4

Source: U.S. Department of Health and Human Services, Supply and Characteristics of Selected Health Personnel, DHHS Publication No. (HRA) 81-10, June 1981, p. 22.

Table 2

Trends in Total Active Non-Federal Physicians (MDs & DOs) per 100,000 Population by County Groups: Selected Years, 1970 to 1979*

AMA County Classification 1978	Estimated MD and DO Physicians per 100,000 Population							
	1970	1973	percent increase over '70	1976	percent increase over '73	1979	percent increase over '76	percent increase 1970 to 1979
Nonmetropolitan Counties								
under 10,000 inhabitants	48	49	2	49	0	50	2	4
10,000 to 24,999 inhabitants	55	55	0	59	7	61	3	11
25,000 to 49,999 inhabitants	72	73	1	81	11	87	7	21
50,000 or more inhabitants	91	93	2	106	14	113	7	24
Potential SMSA Counties	122	125	2	145	16	156	8	28
Metropolitan SMSA Counties								
under 500,000 inhabitants	124	130	5	150	15	163	9	31
500,000 to 1 million inhabitants	146	156	7	182	17	198	9	36
1 million to 5 million inhabitants	178	191	7	215	13	234	9	31
5 million or more inhabitants	220	237	8	256	8	273	7	24

*NOTE: Data for DO physicians are available for 1971, 1974, 1976, and 1981 and in this table estimates were made for other years by interpolation between known years, except 1970 was assumed to be equal to 1971. Other tables do not interpolate.

Source: U.S. Department of Health and Human Services, Diffusion and the Changing Geographic Distribution of Primary Care Physicians, Bureau of Health Professions, Revised November 1983, p. 17.

Number of Wholly or Partly Designated Counties Having a Population-to-Primary Care Physician Ratio Greater than 3500-to-1 and Number of Primary Care Physicians Needed to Reduce the Ratio in these Whole or Part Counties to 3500-to-1, 1982-1994

Year	Number of Wholly or Partly Designated Counties Having a Population-to-Primary Care Physician Ratio Greater than 3500-to-1 1/			Number of Primary Care Physicians Needed to Reduce the Ratio in Whole and Part Counties to 3500-to-1 2/		
	Total	Nonmet	Met	Total	Nonmet	Met
1982	1,501	1,126	375	5,076	2,098	2,979
1983	1,446	1,082	364	4,883	2,018	2,865
1984	1,373	1,033	340	4,696	1,942	2,754
1985	1,311	985	326	4,525	1,859	2,666
1986	1,228	922	306	4,330	1,760	2,570
1987	1,165	865	300	4,114	1,642	2,472
1988	1,095	816	279	3,907	1,542	2,365
1989	1,013	750	263	3,719	1,424	2,295
1990	976	723	253	3,581	1,371	2,210
1991	936	695	241	3,455	1,319	2,135
1992	883	651	232	3,352	1,256	2,096
1993	854	631	223	3,272	1,209	2,063
1994	810	598	212	3,204	1,148	2,056

Source: U.S. Department of Health and Human Services, Diffusion and the Changing Geographic Distribution of Primary Care Physicians, Bureau of Health Professions, Revised November 1983, p. 52.

Table 4

TUITION AND EDUCATIONAL COSTS AT U.S. MEDICAL SCHOOLS

	1982-83 (Actual)	1983-84 (Estimated)	1984-85 (Projected)
Public Schools--Total Costs (In-state)	9,748	10,369	11,308
Public Schools--Total Costs (out-of-state)	12,995	13,991	15,365
Private Schools	17,949	19,599	21,402

Source: "83rd Annual Report on Medical Education in the U.S. 1982-83", Journal of the American Medical Association, (September 22-29, 1983).

FOOTNOTES

[1] U.S. Department of HHS, Supply and Characteristics of Selected Health Personnel, Health Resources Administration, DHHS Publication No. (HRA) 81-20, June 1981, p. 22.

[2] U.S. Department of HHS, Diffusion and Geographic Distribution of Primary Care Physicians, Health Resources and Services Administration, November 1983, p. 17.

[3] W.B. Schwartz, J.P. Newhouse, et al, The Changing Geographic Distribution of Board-Certified Physicians, RAND Corporation, Publication No. R-2673-HHS/RC, October 1980.

[4] J.P. Newhouse, A.P. Williams, et al, The Geographic Distribution of Physicians: Is the Convention Wisdom Correct? RAND Corporation, Publication No. R-2734-HJK/HHS/RWJ/RC, October 1982.

[5] U.S. Department of HHS, Diffusion and Geographic Distribution of Primary Care Physicians, Health Resources and Services Administration, November 1983, p. 52.

[6] NHSC Unpublished data.

[6a] Based on total of average NHSC scholarship awards 1976-77 through 1979-80, from NHSC data.

[7] U.S. Department of HHS, Characteristics of NHSC Scholarship Recipients, 1973-1980, 1981, pp 16-20.

[8] Charles E. Lewis, Rashi Fein, David Mechanic, A Right to Health: The Problem of Access to Primary Health Care, (New York: John Wiley and Sons) 1976, p. 167.

[9] Data presented by Richard Reitmeier, M.D. at Health Resources Administration, "Division of Medicine Conference - Emerging Problems in Graduate Medical Education," May 1983.

[10] Lewis, p. 133.

[11] "83rd Annual Report on Medical Education in the U.S. 1982-1983," Journal of the American Medical Association (September 22-29, 1983), pp. 1502-1519.

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NACHC

STATEMENT OF

THE NATIONAL ASSOCIATION OF
COMMUNITY HEALTH CENTERS, INC.

TO

THE SENATE LABOR AND HUMAN RESOURCE
COMMITTEE

ON

REAUTHORIZATION OF COMMUNITY AND
MIGRANT HEALTH CENTERS AND
THE NATIONAL HEALTH SERVICE CORPS

March 7, 1984

Harvey Holzberg
President

Mr. Chairman, and Members of the Committee:

The National Association of Community Health Centers, Inc., (NACHC) represents a broad cross-section of community-based, public and private nonprofit health centers providing primary care services to medically underserved, disadvantaged populations in all 50 states, Puerto Rico and the District of Columbia. NACHC membership includes many of the nearly 800 primary care centers funded through the Community Health Center (both Rural and Urban health centers) and Migrant Health programs, National Health Service Corps (NHSC) sites, Black Lung Clinics, Maternal and Child Health (MCH) projects, and Urban Indian Health programs. These programs provide health services to more than 5 million Americans. As the national advocate for these centers, and the remaining 20 million who do not have access to basic health services, the NACHC seeks to ensure the continued growth and development of health centers and related primary care programs which provide services to those in need.

Overview of Health Centers

Health centers supported through the primary care program authorities have proven to be effective and efficient providers of quality health care to some 6 million Americans, most of whom have no other available source of care. These include medically (and, often, economically) indigent persons who lack public or private coverage -- including large numbers of the currently unemployed -- as well as Medicare and Medicaid recipients refused care by other private providers (often because of low payment rates or discriminatory practices). In many rural communities, these centers are the only available health care providers for miles. Despite these difficulties and the generally poor health of their patients, the primary care centers have been effective health care providers, according to findings in an overwhelming majority of independent studies over the past decade.

- They have provided continuous, high-quality health care to their patients, and have increased the use of preventive services (such as immunizations and pap smears).
- They have reduced illness and hospitalization rates among their patients (by as much as 50 percent for comparable populations), and yet have held down their costs to a level considerably lower than for other health care providers, which results in tax savings.

These health centers do not interfere with or duplicate the efforts of other private practice providers, but are located in areas where there is a shortage of personal health services. Thus, their role is both appropriate and vitally necessary. The Federal support (both grant funding and placement of health professionals through the NHSC) received by the health centers is used solely to subsidize the cost of care for indigent, uninsured persons, to cover the cost of non-reimbursable services such as preventive service and health education, and to establish the capacity for the delivery of health service in such areas. In effect, the health centers serve to insure their local communities against the cost of care for the uninsured; even if other providers were available to serve these persons, the cost of their care would have to be met through increased taxes.

Recommendation:

In the strongest possible terms we urge reauthoriztaion of the Community and Migrant Health Center programs, as federal categorical programs for a three year period FY 85-87, at the following levels:

PHS ACT		$ in millions		
		1985	1986	1987
CHC	(Sec. 330)	370.7	407.8	448.5
MH	(Sec. 329)	50.8	55.9	60.5

After extensive debate within our organization, which includes members of state and local health departments, on all pending proposals we feel this position best represents local concerns. Adoption of this position versus the Administration's unrestricted Block or the Chairman's proposal, S. 2308, is based upon the real concern that under a State Block Grant, few of the primary care funds would ever reach community-based primary care systems providing services to the truly needy. Moreover, there are a number of concerns about which we feel strongly and need close examination:

- The Block Grant Takes Decision-Making Authority AWAY from the Local Community. Unlike other Federal programs, health centers are locally-sponsored nonprofit organizations with locally-organized governing boards. The block grant would take the decision-making authority AWAY from the local governing board and give it to the state.
- The Allocation Formula: Unfair to All. The proposed formula ensures that all states will share equally in any funding cuts (or increases), regardless of how well or how poorly the pro-

grams are managed. This has the effect of penalizing the efficient centers, and rewarding the poorly-managed sites, no matter how you cut it. It will also unfairly penalize the neediest states. Under the formula, a poor state like Mississippi would lose $2.6 million with a 25% cut in health center funding, while less needier states (of similar size) like Iowa or Utah, would lose much less ($364,000 and $677,000 respectively).

- The States: Unprepared to Manage Primary Care. Most states have no experience managing primary care programs; many states say they will be unable to assume management of these programs for several months, or even years. The development of this new management capacity will be expensive -- it will surely cost more than the 3.7 percent federal administrative "savings" which OMB says would be achieved as a result of the block.
- There Will Be No Flexibility to Respond to National Health Concerns. Problems such as the rapid, unforeseen influx of refugees or undocumented workers, or the interstate movement of migrant farmworkers, may have no resolution. The states themselves have asserted that these are issues of national, NOT state, concern.
- It Will Pit Local Communities Against Powerful State Bureaucrats. Under the block, each funded organization will attempt to maximize its funding. Local communities will have to vie with huge and powerful state bureaucracies. The ultimate losers will be the unorganized, underserved people now being served by the health centers.
- Most states lack the means to identify special need areas and to focus resources on them (GAO reports in 1975 and 1979 criticized states for these shortcomings), and they have tended to shift

block grant resources away from activities they are unfamiliar with -- such as primary care -- and toward more traditional public health services (a 1982 GAO report came to this conclusion).

Next we examined if extension of the existing Block would be satisfactory. Clearly it was not given the experience of the past two years:

- The Primary Care Block Grant (Title XIX, Part C, PHS Act) was created less than three years ago under the Omnibus Reconciliation Act of 1981. The PCBG applies to only one program -- Community Health Centers. Migrant Health, Family Planning, and Black Lung Clinics remained as categorical programs. The fact is that few states have any experience in administering primary care programs. Unlike other blocks, the PCBG is an optional program.
- Despite strong attempts by the Administration to entice States into accepting this Block, only the Virgin Islands currently administers the program. Most recently, West Virginia, the only other State opting for the PCBG, turned it back to the Federal government after the State legislature and governor were convinced that continued administration of the program was not in the best interest of the State and its citizens. Only one other State attempted to apply for the PCBG; its application was approved by HHS, but was later ruled invalid by a U.S. District Court, which pointed out several instances of non-compliance with the law.
- The Administration has consistently refused to comply with Congressional intent in administering this program.
  - HHS summarily merged the PCBG with six other block grant programs in its interim-final and final block grant regulations, despite more than 100 comments

from community health center (CHC) Board officials, executive directors and patients protesting this course of action.

- HHS has completely ignored the Orphan Drug Act's amendments to the PCBG statute passed over a year ago which require separate PCBG regulations addressing the statute's distinctive features.
- Until ordered by a Federal district court to do so, HHS refused to review the substance of any PCBG application, relying instead on self-serving assurances offered by three States. In Society for the Advancement of Ambulatory Care v. Heckler, Civil Action 82-3129 (D.D.C.), Judge June Green totally enjoined implementation of the PCBG program and required HHS to rescind awards made to Georgia, West Virginia, and the Virgin Islands. because HHS's bareboned technical review, exemplified by its approval of facially deficient applications, violated congressional intent. The deficiencies overlooked by HHS are summarized below.
    * Georgia proposed to offer as its State funds "match" income earned by its CHCs, including federal funds. Judge Green had warned HHS in an earlier proceeding that this proposal appeared illegal; however, HHS argued repeatedly that the precise composition of the match was unclear from the application. In sworn testimony, HHS officials finally admitted to the Court that they understood the illegal proposal and neverthe-

less approved the application because this was merely a "compliance" issue to be dealt with, if ever, in year-end audits. Other PCBG violations in Georgia's application included an inadequate fund use description and the absence of any public involvement in its development.

* West Virginia supplied information with its application demonstrating its refusal to guarantee fiscal 1983 entitlement funding levels to each of its CHCs. In addition, the application described a State appeal procedure for CHCs which was not "independent" as required.

- HHS grudgingly conducted a substantive review according to ad hoc procedures and approved a February re-application from West Virginia, effective July 8, 1983. The approval was given despite urgent and repeated protests from several West Virginia CHC representatives that the State had failed to circulate the proposal or otherwise solicit public involvement. Moreover, in making the late year award, HHS unilaterally attempted to reduce the State match obligation from the $1.1 million promised in the application to $100,000, arguing that the State only had to match the remaining two months' worth of Federal funding. Refusing to allow HHS to penalize CHCs for winning a lawsuit, however, Judge Green ordered HHS to ensure the availability of a full Federal allotment and full state match for fiscal 1983.

- HHS has refused to provide the full PCBG allotment to the State of West Virginia. The statute guarantees each participating State precisely the same proportion of CHC appropriations each year as its CHCs collectively received in fiscal 1982. Ignoring this mandate, HHS tampered with the computation by excluding from the formula so-called "phase-out funds" awarded to a few West Virginia CHCs in 1982, reducing the State's share from 1.66% to 1.57%. This tampering resulted in a loss to West Virginia of $300,000 in fiscal 1983 alone, and will result in even a greater loss in fiscal 1984, despite clear indications of the staggering unmet need for health services in the State. Several West Virginia CHCs are suing HHS to obtain the withheld funds.

- Local Community Health Centers have developed excellent cooperative relationships with State officials, in compliance with the Congressional intent found in the categorical Community Health Center legislation.

The simple fact is that no State is now administering the PCBG. Most do not have the capacity or inclination to do so. Extension of the Primary Care Block Grant is certainly not considered a priority of the organizations representing State elected officials. Given the Administration's current position on Block Grants, we feel the PCBG can best be described as "an accident waiting to happen"; and, further, that it is unfair -- and unnecessary -- to leave these programs in limbo any longer.

Mr. Chairman, while we truly appreciate your adoption of a proposal notably different than the Administration's misadventure, we sincerely feel that S. 2308 will only result in a reduction of the required level of commitment from States in order to administer the PCBG.

Since, as we already have mentioned, these programs have functioned extremely well under federal management, we believe they should be extended as federal programs.

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NATIONAL HEALTH SERVICE CORPS

Concerning reauthorizaton of the National Health Service Corps, we are pleased with the Chairman's bill and its recognition of the need for continuation of both the Scholarship and Field Placement programs. We do, however, have some concerns. Accordingly, we support S. 2281 and recommend the following modifications:

1. Existing law should be extended for a three-year period (FY 85-87 at the following levels:

	Field Placement		Total Field	Scholar-ship
	$	P.S. Positions		
FY 85	$ 92 m.	1,580	3,583	*
FY 86	$102 m.	NA	NA	*
FY 87	$112 m.	NA	NA	*

(* Such sums are necessary to support 500 new plus continuation scholarships per year)

Current law should be also amended to reflect the following changes:

2. The definition of Health Manpower Shortage Area (HMSA) should be changed, giving greater emphasis to poverty and other factors identifying problems of access. If this cannot be factored in

immediately, the Secretary should be given 12 to 18 months to do so.

3. NHSC placements of any kind (i.e., Federal salaried PPO, PPA) should be in areas of highest priority determined by a "Placement Opportunity List". However, the Secretary should be required to consider problems of access to care, as well as geographic distribution in determining need. Priority should be given to community-based ambulatory care systems serving needy populations.
4. Concerning Private Practice Option placements, the following changes should be made:
    a. Improved reporting requirements should be developed for PPOs, with penalties for those refusing to see uninsured patients, those not accepting assignments under Title 18 or 19, or those failing to apply a sliding-fee schedule to lower income patients;
    b. Monitoring of PPOs should be improved, which may well require additional positions; and,
    c. PPO placements should be restricted to highest priority HMSA (refer to #3 above).
5. Payback for NHSC personnel should be limited to 110 percent of the previous year's level, and in no event should payback result in the diminution of primary or supplemental health services for health centers or other primary care clinics. NOTE: Recent policy changes have doubled and tripled paybacks for NHSC, resulting in service reductions.

6. In applying for an NHSC placement, community-based primary care clinics should have an option concerning both the individual and payment mechanism (i.e., Federal salaried, PPO, PPA).
7. NHSC State Management Contracts: In awarding such contracts, the Secretary should be required to ensure that State applications spell out a role for groups representing health centers, which, at a minimum, should be consulted in the development of a State's NHSC annual plan. Further, State contractors should be held accountable for monitoring all assignees, including PPOs.

Mr. Chairman, we appreciate the opportunity for public comment.

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TESTIMONY
SUBMITTED TO
THE SENATE HUMAN RESOURCES COMMITTEE

REGARDING
1984 AUTHORIZATION OF THE
VENEREAL DISEASE PREVENTION AND CONTROL PROGRAM
OF THE
CENTERS FOR DISEASE CONTROL

Presented by
Wendy J. Wertheimer
Director of Public and
Government Affairs

VENEREAL DISEASES RESEARCH FUND VD NATIONAL HOTLINE HERPES RESOURCE CENTER (formerly HELP)

Mr. Chairman, on behalf of the Board of Directors of the American Social Health Association and our 40,000 members, I thank you for this opportunity to testify on behalf of the reauthorization of the federal Venereal Disease Prevention and Control Program. As you know, the American Social Health Association is the only national non-profit organization directed solely on the problem of sexually transmitted diseases. Ours is the only voice speaking out in behalf of those infected with these diseases, those at risk, their families, those working to prevent and control the diseases, and those looking for answers through biomedical research.

Our organization has been in operation since 1912, and with a very small budget, we are struggling to fill the gap in services and information left by the federal government, in keeping with this Administration's private sector initiative. But, Mr. Chairman, that gap just keeps getting wider and wider and no effort, no matter how well-intentioned, will succeed in combatting this massive epidemic without the full commitment of the federal government.

Last year our VD National Hotline answered 140,000 callers in need of information and clinic referral. Our phone lines are so jammed by callers that as many as 80% of people who try to call us get busy signals. Our Herpes Resource Center has responded to hundreds of thousands of requests for information. People in this country are in desperate need of answers, answers they are not getting from their doctors, their families, their school nurses, their churches, or even from their local VD clinics.

Three years ago our organization submitted testimony to this Committee when the VD Prevention and Control program was last authorized. At that time we were seeking to separate the VD program from the proposed block grants. We are deeply grateful for the support of this Committee in our efforts. We appreciate your understanding that there are some public health problems that are unique, that are rampant, and that require national coordination. We are delighted that the Administration supports the categorical reauthorization of this program.

These last three years have not been easy ones, certainly not for any of the federal health programs, but bear in mind that the VD program is mandated to control an epidemic of diseases which are highly contagious and wildly out of control. At this point in time, Mr. Chairman, the epidemic of sexually transmitted diseases is more frightening, more widespread, and of greater magnitude than ever before in history. Of all the public health epidemics that plagued nineteenth century society, the only ones left uncontrolled are sexually transmitted diseases. It is incomprehensible to me that in this age when we send men into space with increasing ease and regularity, and when billions and billions of dollars are producing ever more powerful and complex weapons of destruction, babies in this country are still dying of syphilis. The age of Buck Rogers may have arrived, but for one public health problem, we are locked in a time warp in the last century.

Since 1972 the VD control program has suffered from a roller-coaster of funding, and in constant dollars the funding for this program has had no real growth. The real growth has been in the disease rates and the disease incidence of sexually transmitted diseases.

As you know from the testimony of the Center for Disease Control, the VD control program is almost exclusively focused on syphilis and gonorrhea. In fact, the grants to the states devote approximately 75% of the funds to gonorrhea and 25% to syphilis. With limited resources, the program has been forced to make trade-offs in program priorities, and syphilis cases have again risen.

There have been some successes in control of gonorrhea, however, for the first time since the early '70s when the gonorrhea control initiative began. But new obstacles in gonorrhea control may overshadow that success. There has been a six-fold increase since 1979 in cases of gonorrhea resistant to penicillin. Resistance to antibiotics threatens our ability to control the disease and increases the risk of serious consequences.

Thus, we have a VD program which, due to funding, has been barely able to make an impact on syphilis and gonorrhea. Today we know that there are more than 20 sexually transmitted diseases which pose a major threat to our nation, particularly to young people, to women, and their babies. Not only are there more diseases now known to be sexually transmitted, but there are more people at risk, as the "baby boom" babies are now of child-bearing age and they are becoming sexually active at younger ages and marrying at later ages than ever before.

Chlamydia is an organism which causes infections in men and women at rates several times that of gonorrhea infection. In men chlamydia causes non-gonococcal urethritis which may lead to sterility. In women, the consequences of chlamydial infection can be devastating, resulting in sterility or ectopic pregnancy. A study published in 1982 found that stillbirth or neonatal death occurred ten times more often in women infected with chlamydia.

The American Social Health Association has been calling the country's attention to the problem of herpes for many years. In March of 1982 the Centers for Disease Control finally announced officially that an epidemic of genital herpes has indeed been occurring in the U.S. since 1966. Visits to medical practitioners for herpes have increased by more than 1,000 percent. It has been estimated that more than 20 million Americans suffer from herpes, a painful and still incurable disease. Herpes is particularly difficult for women, for whom the disease appears to contribute to a higher risk of cervical cancer. Herpes can be passed to a baby by an infected mother. Of babies infected with herpes, 50% will die, and half of those who survive will suffer permanent neurological damage. The VD program has recently awarded a grant which will provide information about herpes in babies and the extent of the problem.

Probably the least understood aspect of the VD problem in this country is the impact of the diseases on babies. This year more babies will be affected by a sexually transmitted disease than there were children affected by polio during the entire polio epidemic.

There is, in fact, an epidemic of fetal death as a result of these diseases. The rate of ectopic pregnancy in this country has risen dramatically in the last decade, in direct relation to the rise in rates of venereal diseases. More than 52,000 ectopic pregnancies will occur this year, resulting in the death of the babies and serious risk to the mother. At least half of these ectopic pregnancies can be attributed to pelvic infections caused by gonorrhea or chlamydia.

Thus, Mr. Chairman, this year more than 26,000 infants will die as a result of venereal disease-related ectopic pregnancy; babies will be killed or brain-damaged by herpes infection; babies will be killed by the ravages of syphilis; and babies will die in the womb from maternal chlamydia infection. The response of this government to the AIDS epidemic has been questioned by some as insufficient and poorly timed. The epidemic of AIDS deserves every penny it has received, and although it may seem to some that the reponse to AIDS has been slow, it seems remarkable compared to the problem of sexually transmitted disease. There are 3,000 cases of AIDS and well over $40 million being spent by the federal government. We believe this is appropriate, and we strongly support increases for fiscal year 1985. But why has a similar effort not been devoted to sexually transmitted disease in general? At least 30 million Americans suffer from the diseases, and this year alone, tens of thousands of babies will die.

Another sad result of these diseases is an alarming rate of infertility. This year more than 110,000 women of child-bearing age will become pathologically sterile as a result of these diseases, 50,000 of those women will be under the age of 25. We hear often about new technologies producing test-tube babies. The demand for such extraordinary measures could be greatly reduced by reducing the rates of venereal diseases. It is estimated that among my contemporaries, women born in the early 1950s, one out of every 28 of us will be unable to bear children because of pelvic infection.

The problem of sexually transmitted disease is more than a national epidemic, it is a national scandal. No epidemic in medical history has ever been of such scope or magnitude. One out of every 4 Americans between 15 and 55 years of age will be affected by a venereal disease. One out of every 7 teenagers today is infected by a venereal disease. The cost to society is astronomical. But how can you put a price on a baby who has died or to the emotional cost of a hysterectomy at the age of 20?

Until 1972 the federal VD control program dealt only with syphilis. In 1972 authority was added to initiate control of gonorrhea. In 1975 Congress again added authority for the program to prevent and control all sexually transmitted diseases. But at no time since then has the program been given funding necessary to begin to significantly have an impact. With regard to herpes and chlamydia infe~~ctions the~~ problem has also been one of technology and cost. The cost of diagnosing both herpes and chlamydia is very expensive, requiring tissue culture processes. Herpes remains a disease for which no reliable treatment exists, and thus the public health model of diagnosis, treatment, and contact-tracing is impossible. However, the spread of herpes can be prevented. The VD program needs the capability to diagnose herpes and educate and counsel herpes patients to prevent its spread.

But we do not have that luxury due to expense. Luckily research may soon produce some valuable tools for inexpensively diagnosing both herpes and chlamydial infections. These diagnostic tests, when they become available, will make possible some prevention and control of these diseases, and will be a great boon to this program. We are greatly concerned that the authorization levels for the program allow enough room so that when these tests do come on the market the program will be able to initiate comprehensive screening programs in the states.

Until that time there are still important questions that must be answered about herpes and chlamydia and about human papilloma viruses, which may be even more widespread than any of the other sexually transmitted diseases and which may carry even greater risks of cancer. We need to at the least find out just exactly how prevalent these diseases are. We believe that the VD program should institute surveillance programs, or at least selective surveillance programs for herpes, chlamydia, and even human papilloma virus so that when control and prevention is possible, programs can be instituted effectively.

As you can see, Mr. Chairman, penicillin was not the magic bullet that would solve the VD problem. The VD epidemic is complex and interdisciplinary, spanning infectious disease, obstetrics and gynecology, urology, neonatology, virology, and oncology. And yet, a study published in the Journal of the American Medical Association determined that medical students today are woefully undertrained to deal with sexually transmitted diseases. Out of more than 4,000 available medical school training hours, American medical students were being provided an average of only 6 hours training in sexually transmitted diseases. The medical establishment has been just as negligent as the government has been regarding this field of medicine. The ripple effect of this negligence is obvious--poor clinical services, undetected disease, higher disease rates. An additional result is that no incentive is provided to encourage young doctors to devote their energies and careers to this field. The total NIH research budget for all sexually transmitted diseases last year amounted to only $16 million. We are talking about diseases which effect well over 30 million Americans. I do not believe in comparing one disease to another and have refrained from doing so in the past, but comparisons do cry out. Arthritis for example, effects about the same number of people as sexually transmitted diseases. Arthritis, thanks to the hard work of this Committee, now not only receives hundreds of millions of research dollars, but will have its own institute at NIH. I will repeat, sexually transmitted diseases total NIH budget last year was $16 million.

Why should a young doctor choose to devote a career to this field when there is practically no research money, and his background provided by his medical school barely even covered sexually transmitted diseases?

We applaud the VD Prevention and Control program for its initiation this year of an effort to improve clinical training in medical schools. We believe this is a critically important contribution to the control of these diseases. We urge this Committee to include strong report language expressing its support for this effort and its belief that every medical school in this country should institute adequate sexually transmitted disease training programs for its students.

Section 318(b) of the Public Health Service Act provides that five percent of all funds appropriated to the VD program be allocated to programs of information, education, demonstration and research. We are deeply concerned that other program priorities have drawn funds away from this effort, and that the purpose of this legislation has not been fulfilled. Only two projects were funded under this section last year. Education and information are the first line of prevention for these diseases, and the only prevention for a disease like herpes. We believe that this component of the program must have a high priority, and we urge this Committee to include strong report language regarding the importance of carrying out this legislative mandate, especially in educating young people.

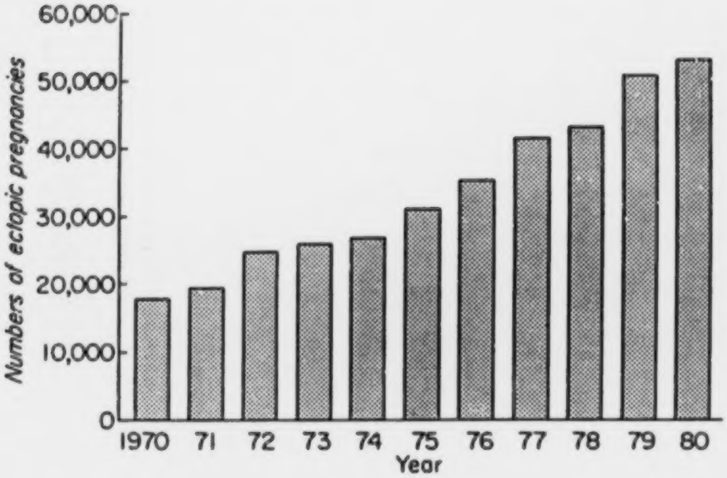
One last concern is that we understand the Administration has proposed to allow for-profit organizations to compete for grants not only for the VD program but for other health programs as well. We urge you to strenuously oppose this attempt. Although this Administration has stated its support for voluntarism and the role of non-profits in taking up the slack where the government has cut back, the fact of the matter is that non-profit organizations are being systematically cut off at the knees. Federal funding cuts have hurt non-profits. OMB regulations have been published which would prevent non-profits who receive any federal funds from lobbying. The new Social Security law required that all employees of all non-profits be enrolled in Social Security by January 1 of this year. For non-profits who had their own pension plans to go immediately into the Social Security system meant substantial cuts in either services or salaries. The Small Business Administration has begun issuing statements that non-profits are unfairly competing with small business. The Senate Finance Committee was to vote yesterday on a cap on tax-deductible charitable contributions. The proposal the Administration is considering to allow for-profit organizations to compete with non-profits for the ever-diminishing funds available to many of us should not be supported by this Committee.

We can put a cap on charitable deductions, we can hold down federal spending, we might even hold down the federal deficit. But we cannot hold down the rates of venereal disease without a massive infusion of funds, a commitment to research, and strong and viable prevention and control program The health of the young people of this nation depends on it. Our record in controlling communicable diseases is clear -- measles, polio, smallpox, rubella, whooping cough. Yet the program to control sexually transmitted diseases has never had the support or the funding to successfully begin to tackle the problem. Each year we delay only brings more monstrous problems. This year there will be 600,000 more cases of herpes, one million cases of pelvic inflammatory disease, 80,000 new cases of syphilis, more than 110,000 women pathologically sterilized, and more than 50,000 ectopic pregnancies.

The epidemic is raging, fueled by complacency, fear, shame, silence, ignorance and inattention. It is within the power of this Committee to begin to change fifty years of institutionalized neglect. We are grateful, Mr. Chairman, for your leadership and compassion for this issue in the past, and know we can count on your support once again. Ours is an issue with too few friends, but we are pleased to count the members of this Committee among them. We urge you to reauthorize the sexually transmitted disease program at $55 million for FY 1985, $65 million for FY 1986, and $75 million for FY 1987 to allow the program a small amount of growth and to begin some initiation of control for some of the diseases other than syphilis and gonorrhea.

I thank you for this opportunity to express our views and look forward to working with you on this important legislation.

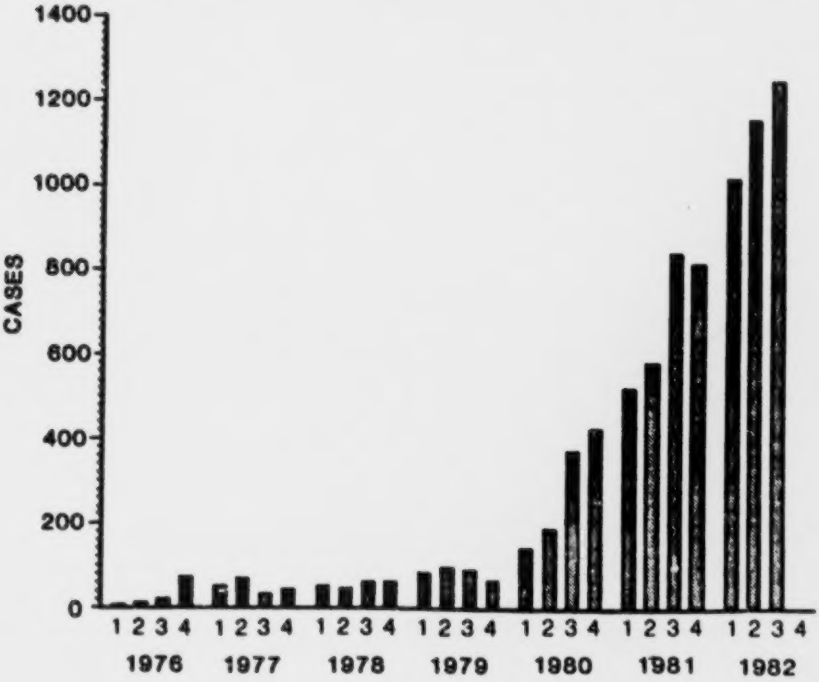
ECTOPIC PREGNANCIES IN THE U.S. 1970-1980

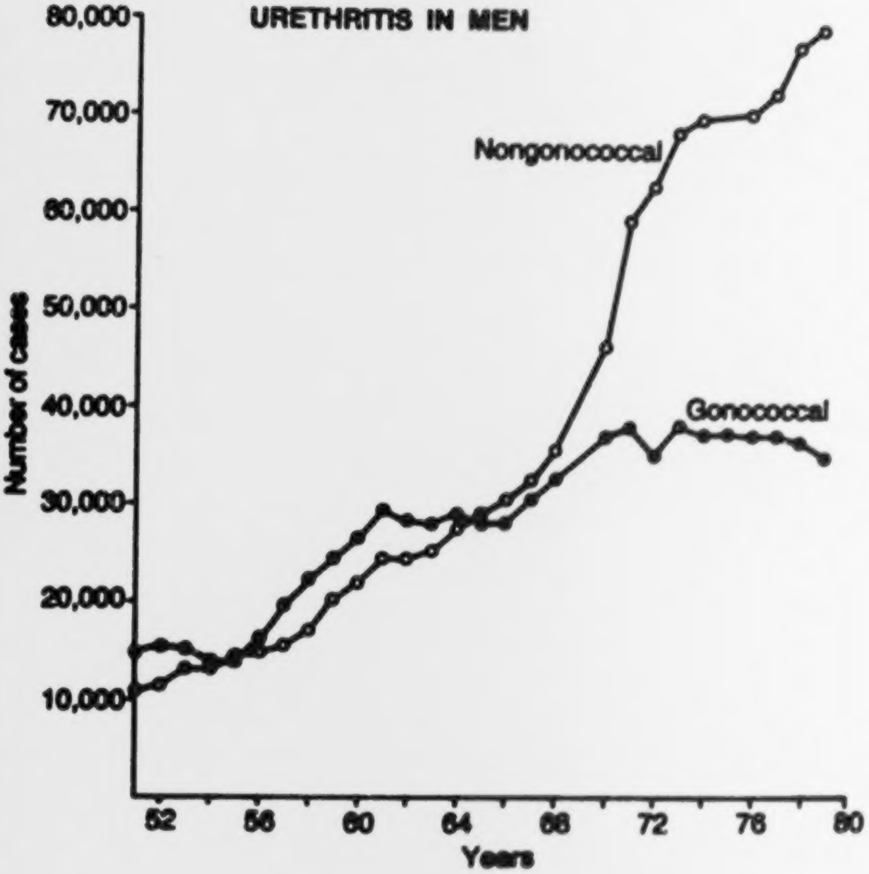


PENICILLINASE-PRODUCING NEISSERA GONORRHOEAE

NUMBER OF CASES OCCURRING BY QUARTER

UNITED STATES (INCLUDING OUTLYING AREAS): 1976-1982




URETHRITIS IN MEN
Nongonococcal
Gonococcal
Number of cases
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
52
56
60
64
68
72
76
80
Years

RECEIVED MAR 5 1984

STATE OF OHIO
OFFICE OF THE GOVERNOR
COLUMBUS 43215

RICHARD F. CELESTE
GOVERNOR

March 2, 1984

The Honorable Orrin G. Hatch
United States Senate
Washington, D.C. 20510

Dear Senator Hatch,

I strongly support the intent of S2281 to revise and extend the provisions of the Public Health Service Act relating to the National Health Service Corps. This program has been vital to the provision of primary health care services in underserved rural and inner city areas of Ohio. I feel the new NHSC scholarship program should be authorized and funds appropriated at a funding level adequate to provide a minimum of 250 new scholarship awards.

I also strongly advocate the reauthorization of Section 330 of the Public Health Services Act to continue the Community Health Centers program at the proposed funding level of $340-million. This level is a reasonable compromise given the serious problem of the federal deficit.

You are to be commended for your insightful support of these vitally needed and cost-effective programs.

Sincerely,

Richard F. Celeste

Richard F. Celeste
Governor

RFC:gjb

American
Dental
Association

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Suite 1004
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March 16, 1984

The Honorable Orrin G. Hatch
Chairman, Committee on Labor
and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Hatch:

I am writing to express the views of the American Dental Association on the legislation, S. 2281, to revise and extend certain provisions of the Public Health Service Act relating to the National Health Service Corps.

Four years ago the Association presented extensive testimony to the Committee on the scope, operation and authorities of the National Health Service Corps. We are pleased to note that, in the intervening period, a number of our statutory and administrative recommendations have been incorporated into the National Health Service Corps program.

The decision of Congress in 1981 to stipulate a formal role for private entities, such as local dental societies, in the proposed designation of health manpower shortage areas has corrected a serious defect in the law. A second area where improvement has occurred involves the licensure of Corps personnel. The American Dental Association had, since the inception of the program, expressed a concern over the failure of many Corps dentists to obtain a license in the state in which they were placed. We are pleased to note that Professional Policies of the National Health Service Corps now require all Corps dentists to be licensed in their state of assignment and that they conduct their activities in full compliance with the respective State Practice Acts during their period of service.

Staffing levels for the NHSC have also been significantly modified in recent years. Data reported by the Department in 1981 indicated a requirement for 2,370 additional Corps dentists to meet the needs of manpower shortage areas. At the time, 355 NHSC dentists were already serving in the field with more than 600 dental students scheduled to graduate over a four year period with a Corps scholarship service obligation.

Today, in response to significant increases in the supply of health practitioners, improvements in the geographic distribution of these providers, and, to a more realistic estimate of Corps members needed to respond to the number of viable sponsors in shortage areas, we note a major reduction in the projected size of the Corps. An an example, the number of dental Corps scholarships has been reduced by 60 percent with less than 10 recipients expected to graduate in 1987 with a requirement for service.

The legislation, S. 2281, to reauthorize the NHSC continues these positive trends in several of its provisions. Section 5 of the bill authorizes "Special Loans for Corps Members to Enter Private Practice." The American Dental Association endorses this proposal as a stimulus to shift the operational thrust of the NHSC away from an over reliance upon fixed-site clinics for the placement of Corps dental personnel. The independent practice model is the dominant characteristic of the dental care delivery system. Because of the profession's emphasis on primary care (approximately 80 percent of all dentists are general practitioners), referral relationships and other linkages which characterize medical care are far less critical to dentistry. The validity of the dental private practice approach as a long-term solution to access problems has been amply demonstrated in those areas of the country where it is economically viable and where it has been promoted by the NHSC.

The American Dental Associaton also supports the intent of Section 6 of the bill directing the Secretary of Health and Human Services to develop and submit to Congress a future staffing plan for the National Health Service Corps with a maximum size of 2,100 or less for all disciplines, dependent upon actual needs of shortage areas. Our past experience indicates there has been a lack of coordination within the Department regarding (1) the scope of the Corps dental program, (2) the actual need for NHSC dental personnel and, (3) the availability, in 01 and 02 priority areas, of viable sponsors and sites in which dentists could effectively serve. Section 6 of S. 2281, as we understand it, recognizes that the number of health manpower shortage areas has and will continue to diminish in response to the growth in the supply of health professionals and the decision of these providers to locate in areas of need. A staffing plan which reflects this pattern and which concentrates the resources of the Corps on those " . . . communities with the greatest need and demand for health care and which have been unable to attract providers of primary care services," will remove much of the controversy which has surrounded the National Health Service Corps program. The stipulation, in Section 6 (c), that the Department must prepare such a plan in consultation with "organizations representing health professionals" will ensure a cooperative effort between the public and private sectors in improving access to care for underserved populations.

The Association does not support the proposal in Section 3 (b) to renew the authorization for National Health Service Corps scholarships. We concur with the Administration's recommendation against additional National Health Service Corps scholarship awards. With the recent re-evaluation of all designated health manpower shortage areas and the resulting reduction in their number, the current supply of dental Corps personnel appears to be adequate to meet the number of requests for Corps dentists in true shortage areas.

A matter which is not addressed in the bill involves the provision of health care to "special population" groups. Under current law, Corps personnel may be assigned to those groups which experience unique cultural or economic barriers to health services. The American Dental Association unreservedly supports efforts to extend health care to individuals who are faced with valid socioeconomic access problems. We believe, however, that it is inappropriate for National Health Service Corps dentists who are placed to serve a special population to also provide routine dental care for those who are able to obtain services in the private sector. Such activities represent a clear duplication of resources and have the potential of adversely affecting the delivery of dental services to those populations which the Corps site is intended to serve. It should, therefore, be stipulated in law that a NHSC dentist who is placed to serve an identified underserved population may provide only emergency services to individuals who are not from such populations.

The 1981 amendments (PL 97-35) to the NHSC recommended specific improvements in the criteria utilized for designating shortage areas. Although the Department has presented a Report to Congress on the Evaluation of Health Manpower Shortage Area Critera, the Report fails, in our opinion, to adequately address the requirements of the amendments " . . . to examine the possible approaches to, and feasibility of, measuring demand and predicting the likelihood that unmet demand in an area will be met within two years." The American Dental Association believes that the present criteria are oriented almost exclusively toward measuring a perceived need for care and fail to consider whether (1) the residents of a community will actually express an effective economic demand for a new practitioners services or (2) whether a demonstrated demand for care can be met by the private sector in a reasonable time period. We therefore urge the Committee to direct the

Department to accelerate its research in this area. The development of revised criteria would seem to be a critical element in the preparation of the future staffing plan for the Corps as required under Section 6 of S. 2281.

In conclusion, the American Dental Association has long recognized the National Health Service Corps as a temporary supplement to the existing dental delivery system within those communities lacking sufficient manpower to meet the demand for dental services. We hope these comments will contribute to the efforts of the Committee to eliminate the remaining barriers to comprehensive health care services.

We respectfully request the inclusion of these remarks within the official hearing record.

Sincerely,

James P. Kerrigan

James P. Kerrigan, D.D.S.
Chairman
Council on Legislation

JPK;nj

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March 20, 1984

The Honorable Orrin G. Hatch
Chairman, Committee on Labor and
Human Resources
United States Senate
135 Senate Russell Office Building
Washington, D.C. 20510

Dear Chairman Hatch:

I am writing to present the views of the American Dental Association on legislation, S. 2301, to revise and extend the Preventive Health and Health Services Block Grant Program.

The creation, in 1981, of the block grant authority consolidated a number of public health categorical activities, including fluoridation, into an omnibus program of allotments to the individual states. At that time, the Association expressed a concern that this restructuring and decentralization of federal assistance would prove inappropriate for community and school-based fluoridation efforts. Fluoridation, we contended, required a national focus in order that government funds could be targeted to those areas which would experience the greatest benefit from this dental disease prevention measure.

Currently, an estimated 123,000,000 Americans have access to water supplies which are either naturally fluoridated or are adjusted to the optimal fluoride level. Children consuming optimally fluoridated water from birth can expect between a 40-70% reduction in dental caries. Many such children reach adulthood totally caries free. A significant increase in the total number of persons benefiting from fluoridation occurred when federal categorical grants were made available beginning in 1979. For example, the first $6 million awarded through this program ($1 million in fiscal 1979 and $5 million in fiscal 1980) provided financial assistance to fluoridate 353 community water systems and 69 independent rural school water systems serving approximately 5.7 million people. In fiscal year 1981, a $5 million appropriation was used to continue 34 statewide grants and to provide second year chemical costs to systems initiating fluoridation in FY 1980. Continuation and new awards in FY 1981 provided financial assistance for the initiation of an additional 368 community fluoridation systems and 33 independent rural school water systems serving approximately 4.7 million citizens -- thus, the $11 million grant program reached an impressive 10.4 million citizens.

It is clear, we believe, that the availability of federal funds earmarked for fluoridation had great success in initiating community water fluoridation. However, when federal funds were shifted from categorical to block grants in 1982, an equally significant drop in financial support for fluoridation programs occurred. A recent survey of 29 state health departments with prior fluoridation funding revealed that under the block grant mechanism 23 experienced a decrease in funding; 9 of which lost funding for fluoridation altogether. The Association can only presume that this trend will continue under the block grant system with the net effect being fewer and fewer children benefiting from fluoridation. Commensurate with this decrease will ultimately be an increase in dental caries along with increased treatment needs and costs.

With only half of the country's population presently benefiting from community water fluoridation, there is a great need for funding above that provided through the block grant authority. There are approximately 50,000 public water systems in the country today that remain unfluoridated. Added to that are the countless thousands of unfluoridated school water systems which serve children in rural areas without public water systems. The previously cited success of the categorical grants available in 1979-82 demonstrates the efficacy of this funding mechanism. The almost immediate impact of the current block grant system on fluoridation has been to reduce the states' ability to continue, let alone expand, fluoridation for the public's benefit. An important factor to consider is the necessity of maintaining fluoridated water systems at the recommended optimal level, which is between .7 and 1.2 ppm. Systems must be regularly monitored and maintained as those allowed to slip below the .7 ppm recommendation become relatively ineffective in preventing dental caries. The block grant system has begun to erode the ability of states to perform this important function.

We are most sensitive to the need for fiscal responsibility. But recognizing that for every $1.00 spent on fluoridation an estimated $50 in treatment costs are saved, we urge the Committee to give consideration to the re-establishment of categorical grant support for fluoridation programs.

We respectfully request the inclusion of these recommendations within the official hearing record.

Sincerely yours,

James P Kerrigan

James P. Kerrigan, D.D.S.
Chairman
Council on Legislation

JPK/pj

DANIEL K. INOUYE
HAWAII

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Honolulu, Hawaii 96850
(808) 546-7550

United States Senate
ROOM 722, HART SENATE BUILDING
WASHINGTON, D.C. 20510
(202) 224-3934

February 29, 1984

The Honorable Orrin Hatch
Chairman
Committee on Labor and Human
  Resources
United States Senate
Washington, D.C.

Dear Mr. Chairman:

I was most pleased by your willingness to incorporate into S. 2301, your proposed Preventive Health Services Block Grant, a special Emergency Medical Services Pediatric Demonstration Program, similar to that which I had introduced earlier this session, S. 163.

I personally am confident that such an initiative will very much be in the best interest of our nation's children and, at this time, I have enclosed, for your formal committee files, a copy of earlier testimony I submitted for the record, addressing the area of prevention and, in particular, the importance of a set-aside under the Emergency Medical Services Program for Pediatric Demonstration Programs.

Aloha,

DANIEL K. INOUYE
United States Senator

DKI:jpl
Enclosure

TESTIMONY OF SENATOR DANIEL K. INOUYE before the Senate
Labor and Human Resources Committee, April 26, 1983 --
PREVENTIVE HEALTH

Mr. Chairman:

I was most pleased to learn that you had scheduled hearings this week in order to ascertain the extent to which the Department of Health and Human Services has been giving priority to various prevention activities. This was a top personal priority of our colleague and former Secretary Richard Schweiker, and I have been most impressed with the extent to which the department has followed through on his recommendations.

Prevention *per se* has been of considerable interest to those of us on the Appropriations Committee for some time now. We have, for example, received testimony that for every dollar expended on prevention, we can expect a savings in excess of $15.00 from our traditional health care system. We have, however, been quite concerned that whereas traditional curative efforts are readily reimbursed under our various federal health programs, that prevention is held to a significantly higher standard. That is, not only must prevention activities be demonstrated to be cost-effective and meaningful, but they must also continue to compete with other worthy programs for our ever-shrinking discretionary health care dollar. Accordingly, I was most pleased to join with you in cosponsoring your proposal, S. 771.

As I have indicated, for several years now, the Appropriations Committee has included specific report language directing the

Department of Health and Human Services to increase its efforts in the prevention arena. Specifically, we have been very impressed with the importance of one's lifestyle on overall health status and the truly exciting promise of "behavioral health/behavioral medicine" initiatives. We have strongly urged the department to seriously address the various recommendations contained in Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention and the more recent publication by the Institute of Medicine entitled Health and Behavior: Frontiers of Research in the Biobehavioral Sciences. At this time, I would like to request that at the conclusion of my remarks three letters which I recently received from the department be included in your formal record. These very nicely highlight the progress that the department has made in looking at the psycho-social aspects of prevention, the importance of providing specific health manpower training resources, and finally provide a more global overview of Dr. Brandt's efforts in this regard.

Today, I would especially like to express my strongest personal support for that portion of S. 771 which would establish a Network of Centers for Research and Demonstration on Health Promotion and Disease Prevention. This original concept was proposed last session by the Association of Schools of Public Health and I feel that it has great promise. Not only would this provide the department with identifiable entities for its prevention activities, but also, as proposed in your bill, would require that it be truly interdisciplinary in nature. I feel that this is especially important given the truly evolutionary nature of prevention. It was only ten years ago that Marc Lalonde, then-Minister of National Health and Welfare for Canada, released this far-reaching and amazingly prophetic report, "A New Perspective on the Health of Canadians". This was the first time that prevention, and particularly behavioral health, was brought into the public political domain. We have come a long way in a very short period of time, and the proposed Network should take us even further.

At this time, I would also appreciate your consideration of including a component in your final bill that would authorize the Secretary of the Department of Health and Human Services to establish, on a demonstration basis, special emergency health care programs for children. The essence of my proposal is included in S. 163. From the information that has been brought to my attention, there can be no question that children are far more than "little adults"; they have unique needs and require special care. Further, apparently, they utilize our nation's emergency rooms far more than most of us would realize. For example, I understand that of all patients receiving care in a hospital emergency department, 20 to 35 percent are children or adolescents. On weekends, and especially at night, they account for more than 40 percent of all visits. Nearly 18 million children receive emergency medical care annually and approximately 100,000 children will be permanently crippled by trauma each year. As much as 55 percent of all deaths up to the age of 15 are due to injuries. Mr. Chairman, in my judgment, statistics such as these strongly suggest that it is in our national interest to provide targeted resources for child-oriented prevention programs.

& HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

The Honorable Daniel K. Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye:

This is in response to your letter of September 16, 1982 which requested a report on the efforts of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to give greater priority to prevention research activities that will address "bad habits"/lifestyle.

As requested by the Committee, we have reviewed the Institute of Medicine Study entitled "Health and Behavior: Frontiers of Research in the Behavioral Sciences" and we believe that this study identifies promising prevention research directions for this Agency and the health research field. The Assistant Secretary for Health has designated ADAMHA to develop a proposal in response to these studies that could contribute to furthering the national research effort in health and behavior. ADAMHA has encouraged and supported this Institute of Medicine initiative from its inception to its completion. Several ADAMHA scientists were invited to participate in the examination of ways in which biomedical and behavioral science can be used to reduce the burden of illness in this country.

Fundamental to our prevention program is an adequate knowledge base which identifies the connection between the condition to be changed and the factors contributing to them. For the past few years, ADAMHA has devoted increasing resources to prevention research. For example, in 1980, a total of $6.7 million was devoted to prevention research. Our 1983 budget for support of prevention research is expected to increase to approximately $11.0 million. These funds will be used to support projects which are wholly or substantially preventive in nature. In addition, ADAMHA supports research projects which are focused in other areas but have a prevention component.

A major focus of the ADAMHA prevention research program will be in support of the Department of Health and Human Services goals (Promoting Health/Preventing Disease: Objectives for the Nation) regarding the health of the American people. A number of the sub-objectives of this endeavor involve the promotion of healthy habits and changing behaviors and include research studies to determine more precisely the links between behavior and health. For example, special attention will be given to preventing the consequences of alcohol use among teenagers and young adults, and in researching the most effective ways of preventing the use of addictive substances by youth.

In 1983, the National Institute of Mental Health will be supporting a number of prevention intervention research centers which will test a variety of interventions with high risk groups aimed at a reduction in the incidence of mental disorders. Alcohol research will give priority to the development of basic techniques to be used in the prevention of alcoholism and the prevention of specific problems that result from alcohol use. Drug abuse research will emphasize research on peer oriented prevention strategies that have proven successful in the prevention of cigarette smoking. These include filmed peer messages, training youngsters to say "no" to drugs, and providing alternative opportunities for positive reinforcement in the home, school and community. One project will evaluate the effectiveness of family therapy in the prevention and treatment of drug abuse. The effect of family treatment on future drug use will be assessed for both adolescent drug abusers and their younger, non-using family members.

In addition, I am currently taking management steps to increase the number of high quality prevention research applications in high priority areas. It is expected that many of these applications will focus on interventions to change behavior.

I hope this information is helpful. If I can be of further assistance, please let me know.

Sincerely yours,

Robert L. Trachtenberg

for William Mayer, M.D.
Administrator

TH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

The Honorable Daniel K. Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye:

I am responding further to your letter of September 16, 1982 about the various preventive activities that the Department of Health and Human Services' Health Resources and Services Administration (HRSA) is currently supporting. I closed my letter with a commitment to provide you with a report of planned prevention activities for the Agency in 1983 after the appropriation levels were established. With the signing of the Continuing Resolution, Public Law 97-377 on December 21, 1982 I am now able to provide you with that information.

This year's planned efforts will again be varied and multi-disciplined in nature, controlled largely by the availability of resources. The major thrust will be in the areas of development of public health programs and the education of professional public health personnel, the teaching of prevention to primary care physicians, nurses and other health personnel, and the assessment of personnel needs for disease prevention and health promotion.

One additional area of involvement will be the Secretary's Award for Innovations in Health Promotion and Disease Prevention discussed in my October 18 letter. HRSA will continue to have the primary responsibility for administering the contest. I am pleased to announce that the first level of screening for student proposals for the award is now underway. The schools are to select winning papers and submit them to their professional associations by January 15. It is expected that winners will be announced in April and the award ceremony will take place in May.

Several new Bureau of Health Professions (BHPr) preventive initiatives planned for 1983 are listed below:

- A new grant program for residency training in preventive medicine authorized under section 793 of the Public Health Service Act will be implemented. There are $1 million available for this program for the year and the first awards will be made in September. This level of funding will support ten projects benefitting 30 residents.

- A series of five workshops addressing various segments of the health work force involved in providing prevention services will be convened. The workshops are designed to explore:

functional implications, optimal utilization including supply, requirements and distribution status, and special training requirements for selected professions in the Nation's health work force in addressing the Objectives for the Nation - Promoting Health/Preventing Disease. This project is authorized under section 708 and will cost approximately $150,000.

- A program for training allied health personnel in disease prevention and health promotion authorized under section 788 (b-e) will be supported. Project support will be provided for selected schools of allied health to develop or enhance their curricula content for improved preparation of allied health students in health promotion and disease prevention, with emphasis on high risk or underserved population groups. It is estimated that this effort will cost $800,000.

- Disease prevention and health promotion activities will be supported to improve the care and well being of the growing elderly population. The support will focus on projects that would provide interdisciplinary team training at the clinical level to improve the health status of the elderly and decrease their dependency. The teams would include such health professionals as physicians, nurses, dentists, physical therapists, occupational therapists, audiologists and dieticians. These projects are authorized under section 788 (b-e) and will cost $900,000.

- During the year a cooperative agreement will be awarded titled "Descriptive Study of Nutrition and Malnutrition of Children in the State of Ponape, Eastern Caroline Islands, Phases 1 and 2." The goals of these phases of the project are to describe the morbidity and mortality related to malnutrition of children from birth to age five and to describe the knowledge, attitudes and treatment/care practices of nurses and other health care personnel. Future phases will: 1) describe the factors in the general population that lead to malnutrition and related morbidity and mortality; and 2) will develop a culturally relevant curriculum for nurses and other health care personnel and will implement and evaluate such a curriculum. The cost of the first two phases will be approximately $405,000 for an estimated two-year period of the study.

- It is anticipated that approximately 30 new nursing research grants will be awarded during Fiscal Year 1983. However, it is impossible to identify the areas of investigation now because awards will be based on recommendations coming out of the three meetings of the National Advisory Council on Nurse Training. On the other hand, it is known that applications for Nursing Research Emphasis Grants for Doctoral Programs in Nursing will be submitted and prevention is one of the topical areas on which they may be focused.

In addition to the new prevention activities, support is to continue this year for the programs listed below that are instrumental in encouraging increased training in prevention even though that is not their primary focus. These programs are also administered in BHPr and the extent of their involvement in prevention was discussed in greater detail in my October 13 letter.

- Area Health Education Centers Program, section 781
- General Internal Medicine and General Pediatrics Residency Training grants, section 784
- Family Medicine grants (Predoctoral Training), section 786(a)
- Departments of Family Medicine grants, section 780
- Physician Assistants Program, section 783
- Nurse Practitioner Program, section 822
- Advanced Nurse Training Program, section 821
- Nursing Special Project grants, section 820
- Public Health Traineeships, section 792

Finally, the National Advisory Councils on Nurse Training and Health Professions Education will meet jointly this month to discuss the impact of the Department's initiative on Health Promotion/Disease Prevention on health professions education. The results of this meeting will be significant in shaping future HRSA support in the area of prevention.

I hope this information will be helpful and thank you for your interest in this important area.

Sincerely yours,

Bob Graham

Robert Graham, M.D.
Administrator
Assistant Surgeon General

TH & HUMAN SERVICES
Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

APR 15 1983

The Honorable Daniel K. Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye:

This is in response to your letter of February 25 regarding Senate report language encouraging the National Institutes of Health (NIH) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to look carefully into the area of prevention research and how such research can include the role of human behavior in preventing and curing diseases.

I can assure you that I fully agree with the report language. In fact, since assuming the responsibilities as Assistant Secretary for Health, I have directed NIH and ADAMHA to increase their emphasis on prevention research. The result has been an increase in the funding of NIH and ADAMHA projects in this area of research from approximately $556 million in FY 1981 to about $708 million projected for FY 1984.

Throughout its existence the Public Health Service (PHS) has always supported a variety of programs in the area of disease prevention and in recent years efforts have increasingly focused on promoting healthy lifestyle practices. The 1979 Surgeon General's Report on Disease Prevention and Health Promotion intensified these efforts by establishing broad national goals to be achieved by 1990. Achievement of these goals has required participation by both the private and public sectors. I am pleased to report that we have made good progress in a number of specific areas. For example, we have succeeded in immunizing over 95 percent of children entering school against childhood communicable diseases. We have surpassed our 1990 goal for nearly eradicating polio and diphtheria and by next year expect to achieve our goal of eradicating indigenous measles in the United States. In the area of cigarette smoking, the proportion of adult males who smoke has declined from 52 percent in 1965 to 38 percent in 1980 and for adult women that proportion has decreased from 34 to 29 percent.

You also expressed concern that priority be given to minority mental health professionals. In accordance with the Senate Report language, the National Institute of Mental Health is specifically requesting applications in the area of minority training, prevention and child mental health. Further, funds will be provided to continue all current grants in the minority fellowship program and paraprofessional mental health worker training projects.

Your interest in PHS programs is appreciated and you may be assured that our efforts in these important areas will continue.

Sincerely yours,

Ed Brandt
Edward N. Brandt, Jr., M.D.
Assistant Secretary for Health

National Conference of State Legislatures

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President
Miles 'Cap' Ferry
President of the Senate
State of Utah

Executive Director
Earl S. Mackey

April 5, 1984

The Honorable Orrin Hatch
Chairman
Committee on Labor and Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Senator Hatch:

On behalf of the National Conference of State Legislatures I want to take this opportunity to commend the Senate Labor and Human Resources Committee in reporting the preventive health block grant (S.2301). The Conference has long supported the consolidation of federal categorical programs, which allows the states increased flexibility, better targeting and more efficient use of funds. Consolidation has also lessened administrative costs and simplified funding, reporting and auditing procedures.

NCSL is particularly pleased that funding levels for this block grant have been increased including higher funding for child immunization and new funding for programs for home and community based health care. States are rapidly moving to provide alternatives to institutionalization for the elderly and this measure provides the incentive to augment those efforts. In addition we welcome directions given the Secretary of the Department of Health and Human Services to develop with the assistance of appropriate national organizations "model criteria" that will enable the states to better share data and information. We hope that the committee will emphasize the precedent set in the Omnibus Budget Reconciliation Act of 1981 on these requirements and direct the Secretary that they shall not be "burdensome". I offer the assistance of the National Conference of State Legislatures in this endeavor.

NCSL has recently completed a survey of 33 states and found that they are, overall, meeting the expectations of the Congress in administering and monitoring the block grants. State legislatures are: developing systems to review grant applications, holding hearings to monitor the effectiveness of programs and auditing funds distribution. We will be happy to share the survey's results with the committee.

Again, I thank the committee on its efforts and look forward to working with you in the future.

Sincerely,

Hugh T. Farley

Senator Hugh T. Farley,
Chairman, NCSL Human Resources
Committee

American Hospital Association

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Suite 500
Washington D.C. 20001
Telephone 202.638.1100
Cable Address: Amerhosp

March 7, 1984

Honorable Orrin G. Hatch
Chairman
Senate Labor and Human Resources Committee
428 Senate Dirksen Office Building
Washington, D.C. 20510

Dear Chairman Hatch

The American Hospital Association, which represents approximately 6,300 member hospitals and health care institutions, as well as more than 35,000 personal members, is pleased to have this opportunity to share its views with the Committee on S.2281, the National Health Service Corps (NHSC) Amendments of 1984.

The AHA supports the work of the NHSC and views it as a primary force in meeting the needs of medically underserved areas. Although the increasing supply of physicians and other health professionals has reduced the number of health manpower shortage areas (HMSAs), certain sections of the nation may never, due to economic, social or environmental concerns, be able to attract and retain needed health personnel. Section 3 of the bill would authorize funding for 150 new scholarships in each of Fiscal Years 1985 through 1987. We support this provision as a means of assuring a dependable source of scholarship-obligated practitioners until such time as the Department of Health and Human Services (DHHS) is able to develop a long-range staffing plan to provide health care personnel to underserved areas.

In addition, we support Section 5 which would continue the Private Practice Option (PPO) for obligated physicians. The AHA's Section for Small or Rural Hospitals has, in the past, worked with the American Medical Association in a program to attract NHSC physicians to practice in HMSAs. We particularly focused on the PPO, stressing that the commitment to develop an independent private practice is more likely to result in permanent residence and service to a community.

Based on our agreement with AMA, the Section publicized the PPO to small or rural hospitals. Those small or rural hospitals that met the criteria established by the NHSC then completed a questionnaire detailing their available positions. These in turn were forwarded to the AMA where staff refined the responses and forwarded them to the NHSC.

Approximately 4,000 letters were mailed in October 1982 to small or rural hospital administrators indicating that the program was available. By February 1983, the AMA had received 250 written responses from small or rural hospitals. In addition, both the Section and the AMA received a large number of phone calls requesting further information or expressing general interest. We were encouraged by the initial response to the Section/AMA effort and by the fact that hospital-sponsored opportunities appeared to be those most readily embraced by obligated physicians.

The AHA believes there always will be a need for physician placement by the NHSC in medically underserved areas. The PPO enables a physician to establish an involvement and commitment to a community--one that is more likely to result in permanent settlement. From the perspective of equity and adequacy of health care services, the NHSC and the PPO serve a significant role for small or rural hospitals and their communities.

The American Hospital Association commends the Committee for its efforts to relieve the health manpower maldistribution problem. We appreciate the opportunity to present our views and would be pleased to provide any further information or assistance that its members might request.

Sincerely

Jack W. Owen

Jack W. Owen
Executive Vice President

AMERICAN
ASSOCIATION
OF DENTAL
SCHOOLS

1625 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036

202/667-9433

March 5, 1984

Honorable Orrin G. Hatch
United States Senate
Washington, D.C. 20510

Dear Senator Hatch:

The American Association of Dental Schools appreciates this opportunity to comment on S. 2281, a bill to revise and extend provisions of the Public Health Service Act relating to the National Health Service Corps. The American Association of Dental Schools (AADS) represents all sixty dental schools in the United States and is the only national organization devoted exclusively to the needs of dental education.

Our comments are submitted in support of S. 2281, National Health Service Corps Amendments of 1984. Our constituency recognizes that the purpose of the National Health Service Corps is "to improve the delivery of health services in health manpower shortage areas." Although there has been a reduction in the number of health manpower shortage areas generally in recent years, there remains a number of underserved areas which still require dental practitioners. The need for dental personnel willing to provide care in geographically underserved areas or to specific underserved populations is significant. According to 1983 data, the number of states with federally designated dentally underserved areas is as follows: Twenty-seven (27) states have 1-9 areas or populations that are underserved; seventeen (17) states have 10 to 19 areas or populations that are underserved; two states, and the Commonwealth of Puerto Rico, have 20 to 29 areas or populations that are underserved. These data make it clear that there is a definite need to sustain a modest number of dental personnel willing to practice in federally designated underserved areas. The authorization levels contained in the bill are comparable to FY 1984 appropriations. They constrast with the Administration's proposal to zero out the NHSC scholarship program and to cut the field service program by almost 25 percent. The authorization will support 150 new NHSC scholarships of which dentistry can anticipate 13-14 scholarships per year. This modest scholarship program will provide a limited number of practitioners eligible to serve in the numerous areas of the country that still require critical dental care.

The AADS supports the directive contained in the bill that the Secretary of Health and Human Services develop a long-term staffing plan which allocates corps personnel to communities with demonstrated need and demand for health care. Our association believes that despite the impact of "market forces", there will remain numerous communities that dental care providers will consider financially unattractive. As the cost of dental education and the level of student indebtedness continue to increase, underserved communities may find it increasingly difficult to attract and support new dental practitioners. Therefore, we endorse the concept inherent in the long-term plan that the most needy communities will not be overlooked in corps placements.

As we review S. 2281, we interpret Section 6(c) to mean that Congress intends that the Secretary of Health and Human Services must consult with appropriate health professions organizations in the development of the long-term plan. Since the American Association of Dental Schools is the only national organization that represents the interests of dental education exclusively, we will anticipate an invitation to participate in the development of the plan. Accordingly, we offer our resources to the Congress and the Secretary in support of this legislation.

Sincerely,

Owen R. Terry
Interim Executive Director

ORT/jf

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
1117 North 19th Street • Arlington, Virginia 22209 • 703/525-4200

April 6, 1984

The Honorable Orrin G. Hatch
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The American Academy of Physician Assistants, the national professional society for physician assistants, is pleased to submit its recommendations regarding reauthorization of physician assistant educational program assistance. For FY 85, 86 and 87 a minimum authorization of $5 million is needed for physician assistant programs to continue to recruit, educate and deploy physician assistants.

Cost Effectiveness

For over a decade, Congress and past Administrations -- Republican and Democratic alike -- have supported the development of the PA profession because of the potential for reducing health care costs and for providing health care in underserved areas. The potential for cost savings in the provision of health care by utilization of physician assistants has never been more important than it is today. As health care expenditures continue to rise on a national level, physician assistants offer the most significant means of reducing costs while maintaining the level of the quality of services provided.

This is derived through comparatively low cost education, good utilization of skills and knowledge, decreased patient waiting time, and increased time spent with patients by practitioners. It has been demonstrated conclusively that practices which employ PAs provide more patient visits per $1,000 cost, better care and lower overall expenses than similar physician-only practices.

Deployment

Unserved and underserved areas of our nation continue to experience problems associated with the inaccessibility of health care, despite the projected physician surplus. Physician assistant deployment data, gathered by the Association of Physician Assistant Programs, indicate that 26.3 percent of all practicing civilian PAs are located in communities with a population size under 10,000 and that an additional 36.8 percent of all practicing civilian PAs are located in communities with a population size of more than 250,000. Clearly, physician assistants continue to make a contribution to solving the problem of maldistribution of health care personnel by locating in underserved areas such as rural communities and large inner city areas.

Utilization

Continued federal support of physician assistant educational programs is important because of the potential for increased utilization of physician assistants in extended care facilities, nursing homes, and as providers of home health care. In addition, because of PAs' patient education skills and increased time spent in patient counseling, they are able to play an important role in disease prevention and health promotion. Continued federal support will enable programs to further develop these aspects of their curricula and evaluate teaching methodologies for effectiveness.

Furthermore, advances in PA education, including enhanced skills in geriatrics, health promotion and disease prevention, and substance abuse counseling have elevated the importance of PAs as providers beyond an already significant role in the provision of health care. Health care leaders acknowledge the importance of the patient's role in maintaining good health by observing good health practices. It is equally important to recognize those health care providers who are capable of providing the patient counseling services necessary to achieve this goal.

In today's health care market, we cannot overlook those forces which will stimulate new demand for physician assistant services. For example, new federal initiatives to contain costs through the use of diagnostic related groups for determining reimbursement levels may, in the long run, increase the utilization of physician assistants as providers in hospital settings. Also, because prospective payment systems may result in early discharges requiring home health care services, nursing home rehabilitation and increased ambulatory care, the demand for physician assistant services can be expected to rise.

New federal initiatives notwithstanding, data collected by the Association of Physician Assistant Programs show that the utilization of physician assistants in hospitals and non-hospital ambulatory clinics has more than doubled over the past decade. Furthermore, the percentage of physician assistants employed in private solo practices and private group practices continues to remain steady. Clearly, the health care marketplace has demonstrated a continuing need for physician assistants to meet the health care needs of this nation.

Federal Support of Physician Assistant Programs

Currently 39 programs are receiving FY 84 federal financial support which covers only a portion of their total operating budgets. These programs are expending funds allocated for the first year of a three year grant cycle. The Bureau of Health Professions administers physician assistant grant programs which operate on a three year grant cycle. Grant requests are reviewed by a committee and are either approved or disapproved for funding based on that review. According to figures released by the Bureau of Health Professions, it has approved physician assistant program grant requests totaling $6.6 million for FY 85.

Because of reductions in federal support, some programs have been forced to increase their tuition costs significantly, thereby preventing a segment of the population from entering the PA profession. Currently, physician assistant students come from a broad section of socio-economic groups. Information being collected from member programs of the Association of Physician Assistant Programs gives us a preliminary indication that over 90 percent of PA programs are raising their tuition fees an average of 15-20 percent, in some part to cover reductions in federal support.

The institutions which sponsor physician assistant programs continue to demonstrate their support of these programs by absorbing the administrative costs related to integrating PA students into existing medical education courses. Physician assistant programs are divided equally among private and public schools. Given the differing financial structures of these two types of institutions, reductions in federal support more directly affect private institutions which do not have any recourse except tuition increases to maintain these programs.

It should be apparent that given the rising cost of physician assistant education, federal support has not contributed to subsidizing lower tuition fees, but rather has provided for improved quality of education for physician assistant students. Over the past decade of federal support for PA programs, a number of evaluative studies have measured the effectiveness of programs in educating primary care providers. This evaluative process has led to a number of innovations in medical education.

For example, PA educators have pioneered the use of clinical algorithms, patient management problems, computer-based clinical simulations, and patient instructors in their programs. Also, they have been innovative in the development of new teaching methodologies in clinical behavioral sciences and clinical interpersonal skills. Patient education, interviewing and history taking, health counseling, and preventive medicine are recognized within PA programs as integral parts of a comprehensive primary care education. Finally, PA programs have demonstrated how practitioners can be employed in medically underserved areas after completing educational preceptorships in those areas.

A unique and often overlooked aspect of federal support of physician assistant programs is the networking and sharing of information that occurs among programs. Many programs receive federal demonstration grant awards which enable individual programs to develop a particular aspect of program curriculum, a particular teaching methodology or evaluation tool. The results of these efforts are then shared with the 53 member programs of the Association of Physician Assistant Programs which represents virtually all accredited physician assistant programs. This results in the most cost effective use of federal funds to enhance physician assistant education, deployment and practice.

In FY 84 physician assistant program grant requests totaled $6.9 million. However, Congress appropriated only $4.7 million of the $6.0 million authorized. This level of funding has caused programs to increase tuition, curtail important educational projects, and reduce faculty and staff. All of these actions impact adversely on physician assistant education and the ability of the profession to fulfill its role as an important part of the nation's health care delivery system. For FY 85, 86 and 87 we strongly urge you to authorize $5 million annually for physician assistant educational program assistance.

Thank you for allowing us the opportunity to submit these recommendations.

Sincerely,

Charles G. Huntington

Charles G. Huntington, PA-C
President

Senator **Kennedy**. The committee stands in recess.

[Whereupon, at 12:15 p.m., the committee was adjourned.]

BLOCK GRANTS AND OTHER HEALTH SERVICE PROGRAMS, 1984

WEDNESDAY, MARCH 14, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to call, at 10:15 a.m. in room SD-430 of the Dirksen Senate Office Building, Senator Orrin Hatch (chairman) presiding.

Present: Senators Hatch, Kennedy, and Pell.

OPENING STATEMENT SENATOR HATCH

The CHAIRMAN. Today I am pleased to chair the full Labor and Human Resources Committee hearings related to the Nurse Education Amendments of 1984 and the Health Professions Training Assistance Act of 1984. The programs this legislation reauthorizes are found in title VII and VIII of the Public Health Service Act and have a proud history of demonstrating a Federal response to concerns expressed by our citizens over the years related to inadequate access to health care.

These efforts have proven to be very successful and in fact have provided the resources to accomplish much of what Congress intended over the past 20 years—to increase the numbers of health care providers, to encourage careers in family medicine and other primary care specialties, and to diminish the barriers to a career in health care by providing needy students with some financial assistance.

But today's needs are much different from what they were 20 years ago. In fact, health education is at a crossreads in our history. Thanks to our past Federal efforts, in cooperation with State initiatives, we are rapidly approaching a time when there will be an adequate number of health professionals in most categories and in most regions of our country. There has been a dramatic increase in the number of physicians, nurses, dentists, and allied health personnel. In fact, there are almost twice the number of students graduating each year from our medical and nursing schools today than there were 20 years ago.

This supposed success has made many people nervous. In fact, the 1981 report of the Graduate Medical Education Advisory Committee suggests there will be a significant surfeit of physicians by 1990, possibly as many as 70,000 more medical doctors than are required to provide adequate medical services. However, these projections for excess numbers of physicians vary according to medical specialty, and the same report estimates there will be ongoing needs for more primary care physicians, rehabilitation specialists, and preventive and public health experts.

So in spite of an overall abundance of health care providers, I believe it essential we maintain our present programs which train individuals capable of providing primary health care services, and particularly those who can serve in medically needy areas. This requires we focus our health profession and nurse training legislation to accomplish just those things.

During today's hearing, I particularly want to focus on nurse training, education, and research. The Congress, recognizing the need for programs to increase the supply and improve the education of registered nurses, established the Nurse Training Act in 1965. Nineteen years and some $1.6 billion later, the number of registered nurses has doubled, improving both the distribution to rural and urban underserved areas and the quality of nursing services to the nation as a whole.

However, since World War II, the Nation has faced an overall shortage of nurses in both hospitals and nursing homes. The growing need for nurses resulted in Federal support until 1976, when President Carter stated that there was no longer a national nursing shortage.

Had the shortages and maldistribution problems been met? What did $1.6 billion buy in the way of nursing care? In short, had the need for Federal support to nursing education ended?

The Nurse Training Act Amendments of 1979 mandated a study that would determine the answers to these questions. The Institute of Medicine was to conduct the study and completed their work on that project in January 1982. The result was a 300-page document listing some 21 recommendations to Congress regarding nursing practice and nursing education.

These recommendations stated that no Federal support to increase the overall supply of nurses was now needed, but certain Federal, State, and private actions were recommended to alleviate particular shortages and needs.

Today's hearing will focus on the reauthorization of that act and the future role the Federal Government can play in supporting nurse education, practice, and research.

The bill I will introduce to reauthorize the Health Professions Training Assistance Act is also tailored to meet today's needs. Access to health care today is far less a problem than it was a decade ago, but access by students to a career in health is a problem. Therefore, reauthorization of the Health Professions Training Assistance Act will continue current programs which provide loans for needy students, provide Federal loan insurance for students pursuing post baccalaureate training in health careers, provide funds for students with exceptional financial needs to insure the economically disadvantaged an opportunity to become health professionals, and increase our ability to reach out to minority students to become health professionals. Furthermore, I believe it essential we maintain our support for family medicine and the other primary care specialties, given their importance to our health care system by their capacity to provide comprehensive and economic care. This bill also repeals several obsolete or redundant sections of title VII, emphasizing current concerns and targeting the Federal effort on student indebtedness and primary care training.

So I am really happy to welcome this morning's witnesses, and we will start with the administration. Before we do that, we will turn to our ranking minority member, Senator Kennedy, for any comments he may have.

Senator KENNEDY. Thank you very much, Mr. Chairman.

Today's hearings on health professions education are of critical importance. Four years ago, I stated that I believed that the goals of the health care system in the United States are to provide all Americans with equal access to high quality health care at a reasonable cost, to promote good health and prevent disease, to return individuals who are acutely ill to good health, and to improve the quality of life for individuals who are chronically ill or disabled I still believe in these goals. We must continue to provide qualified health personnel who are prepared to meet the needs of the people of this Nation: black and white, rich and poor, farmer and city dweller.

For more than two decades, we have had a partnership with the Nation's health professions schools and students to meet our needs for qualified health professionals. Working together, we have dramatically increased our Nation's capacity to train health professionals, we have encouraged a renewed interest in primary care, and we have established a national health service corps that has the potential for fielding almost 3,600 physicians and other health professionals in 1985 to meet the needs of the underserved.

Despite the fact that we have made substantial progress in solving the problems that were first identified years ago, much remains to be done. Many low- and middle-income Americans may no longer be able to afford the price of education in our health professions schools. Four years ago, I noted that high levels of student indebtedness will frustrate our efforts to continue to improve appropriate specialty and geographic distribution among our health professionals. This warning is still true today. We must be doubly concerned about the reality that under our current system of payment for health services these high levels of indebtedness will surely be passed along in higher costs to those seeking health care.

A student's ability to pay for education must not become an implicit or explicit admission criterion. We must have health care professionals who come from all areas of our society: women, minorities, low-income whites, and the physically handicapped.

Our Nation's nurses are essential to our ability to provide health services and are critical members of the health care team. Without them, our ability to meet the health needs of our citizens is jeopardized.

A recent study on nursing and nursing education completed by the Institute of Medicine concluded that as of the fall of 1982, there was no longer a generalized national shortage of RN's or LPN's. However, there are identified shortages that occur unevenly throughout the Nation in different geographic areas, in different health care settings, especially those that serve the economically disadvantaged and in specialty nursing. Thus, there continues to be a need for Federal support for nursing programs.

The problems of geographic and specialty distribution of our health professionals are persistent. Nine years ago, as chairman of the Subcommittee on Health of the Committee on Labor and Public Welfare, I conducted hearings on geographic and specialty maldistribution. I am pleased that progress has been made in reducing the magnitude of the problems, but I believe that we must not relax our concerns about these issues. I am not prepared to deny the poor of rural America and inner-city neighborhoods access to primary health care on the basis of vague assertions that market forces will take care of their needs.

The Reagan administration has proposed some $80 million in reduced funding for health professions training, including reduced funding for physicians, nursing, pharmacy, veterinary medicine, and public health training. Mr. Reagan's premise seems to be that the market and free enterprise will take care of our future needs, so a fiscal 1985 budget that is less than one-third of fiscal 1981 is justified. Mr. Reagan's view on health professions is unacceptable.

It is clear that this committee should report out authorizing legislation that rejects the premises found in the President's fiscal 1985 budget proposal for health professions education.

The proposed $38 million reduction in nurse training from fiscal 1984 levels is unacceptable. The proposed $30 million reduction in primary care/family medicine program support is unacceptable. The proposed $8 million reduction in area health education centers is unacceptable. And the proposed $7 million reduction in public health program support is unacceptable.

I intend to work with the members of this committee on legislation responsive to the current needs of our society for qualified trained health professionals. I will shortly introduce a health professions bill which will include provisions for appropriate authorization levels for existing health professions programs, make provisions for a modest scholarship program for low-income students, minorities and handicapped students and create a modest service contingent loan forgiveness program.

I am looking forward to the testimony of today's witnesses. I believe their comments will be helpful in guiding the Senate toward effective legislation on the issue of Federal funding for health professions education.

They are familiar figures to our committee and they have always been extremely responsive to our questions and extremely helpful to this committee in the past, and I join in welcoming them to our hearing today.

Thank you very much, Mr. Chairman.

The Chairman. Thank you, Senator Kennedy. I am pleased to welcome the administration here today, represented by Dr. Edward N. Brandt, assistant secretary for health, Department of Health and Human Services, accompanied by Dr. Robert Graham, administrator, Health Resources and Services Administration.

Before you begin we will insert the prepared statement of Senator Grassley in the record.

[The prepared statement of Senator Grassley follows:]

STATEMENT OF SENATOR CHARLES E. GRASSLEY BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES HEALTH REAUTHORIZATION HEARING(III), WEDNESDAY, MARCH 14, 1984.

MR. CHAIRMAN, I LOOK FORWARD TO OUR DELIBERATIONS ON THE TWO VERY SUCCESSFUL PUBLIC HEALTH SERVICE ACT PROGRAMS ON WHICH THE COMMITTEE WILL TAKE TESTIMONY TODAY. BY MOST ACCOUNTS, TITLE VIII FOR NURSE TRAINING AND TITLE VII FOR HEALTH PROFESSIONS TRAINING HAVE BEEN AMONG THE MORE SUCCESSFUL PROGRAMS AUTHORIZED UNDER THE PUBLIC HEALTH SERVICE ACT. SO MUCH SO, IN FACT, THAT, AS YOU POINTED OUT IN YOUR OPENING STATEMENT, WE ARE NOW BEGINNING TO FOCUS ON WAYS TO MORE PRECISELY TAILOR THESE PROGRAMS TO MEET REMAINING SPECIAL NEEDS. I HOPE THAT THE TESTIMONY WHICH WILL BE GIVEN BEFORE THE COMMITTEE TODAY WILL HELP US GET A MORE DISCRIKINATING APPRECIATION OF WHAT ARE THE MOST IMPORTANT AND NECESSARY FEATURES OF THESE PROGRAMS UNDER PRESENT CIRCUMSTANCES.

IT IS, OF COURSE, CLEAR THAT WE CANNOT MEET ALL OF THE DESIRES OF THE GROUPS WHO WILL APPEAR BEFORE THE COMMITTEE ON BEHALF OF THESE PROGRAMS. IT IS OUR UNPLEASANT TASK TO RECOGNIZE MUCH MERIT IN ALL OF THE PROGRAMS WHICH ARE URGED ON US BY THE KNOWLEDGEABLE PEOPLE WHO REPRESENTING THESE PROGRAMS, YET AT THE SAME TIME TO REALIZE THAT, IN OUR PRESENT CIRCUMSTANCES, THIS CONGRESS HAS A MAJOR PROBLEM TO DEAL WITH IN THE FORM OF LARGE FEDERAL DEFICITS, NOT JUST IN THE NEXT FISCAL YEAR, BUT QUITE PROBABLY IN ALL THE FISCAL YEARS COVERED BY THE REAUTHORIZATION PERIODS OF ALL THE BILLS WE ARE CONSIDERING.

I AM AWARE THAT WE SHOULD NOT MAKE THE MISTAKE OF BEING "PENNY WISE AND POUND FOOLISH"; AND CLEARLY MANY OF THE PROGRAMS WE ARE REAUTHORIZING CAN GENERATE ULTIMATE COST SAVINGS. BUT AT THE SAME TIME IT SEEMS TO ME THAT WE HAVE TO TAKE A HARD LOOK AT ALL THE PROGRAMS WE REAUTHORIZE THIS YEAR. WE WILL HAVE TO BE DISCRIMINATING. PERHAPS WE SHOULD SUPPORT GENEROUSLY INCREASED AUTHORIZATION LEVELS FOR SOME PROGRAMS: PERHAPS WE SHOULD NOT. AS I SAID BEFORE, I THINK THAT THE GROUPS WHO APPEAR BEFORE THE COMMITTEE CAN HELP US MOST BY IDENTIFYING THEIR HIGHEST PRIORITIES RATHER THAN BY URGING ON US THEIR MAXIMUM PROGRAM WHICH INCLUDES EVERYTHING THAT A PERFECT WORLD MIGHT OFFER.

THANK YOU.

The CHAIRMAN. So, Dr. Brandt, happy to have you here once again. You have spent a lot of time in this committee, but we appreciate it.

STATEMENT OF EDWARD N. BRANDT, JR., M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT GRAHAM, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Dr. BRANDT. Thank you very much, Mr. Chairman and Senator Kennedy, I am happy to have the opportunity to appear before you today to discuss the administration's views on the proposed extension and amendment of the health professions and nurse training authorities in titles VII and VIII of the Public Health Service Act, as well as to consider certain issues related to the future role of the Federal Government in the field of nursing research.

As both of you have pointed out, shortages of specific types of health professionals in particular geographic locations or settings continue to exist. Opinions, however, differ on the exact dimensions of the shortages and how best to remedy them.

Traditionally, State and local governments, health professions schools, professional organizations, and other nonfederal groups have taken a major responsibility for the solution of problems of health professions education and practice. We believe that these non-Federal groups should continue to play a central role in this field.

In considering reauthorization of the health professions and nursing authorities for fiscal year 1985 through fiscal year 1987, we have assumed that the Public Health Service will continue to provide leadership in defining directions and anticipating needs, primarily through information—gathering, selected financial aid, and technical assistance.

Mr. Chairman, the administration's highest priority in the health professions field at this time is to increase the numbers and improve the capability of health care providers serving minority and underserved populations. Other major objectives include promoting a sufficient supply of primary care physicians, strengthening training in health promotion and disease prevention, supporting certain other health professions initiatives, and improving the training and utilization of nurses. Our reauthorization proposal addresses these objectives.

Increasing the numbers and capability of providers serving minority and disadvantaged populations can be accomplished in part by recruiting more health professionals from among these groups.

Despite some advances in recent years in providing for equity of access to health professions careers for individuals from economically disadvantaged and minority groups, recruitment of such individuals continues to lag.

Federal initiatives to provide educational assistance to health professions students from disadvantaged backgrounds have been vigorously pursued since the early 1970's. Measurable progress has been made; however, much remains to be done.

The administration proposes to fund the disadvantaged assistance program at $24 million in fiscal 1985, about one-third higher than the current level of $18 million.

Certain predominantly minority health professions schools have played a special role in training individuals from disadvantaged and minority backgrounds. The Advanced Financial Distress authority, established in fiscal year 1982, has permitted multiyear support to selected schools to the extent essential to remove these schools from serious and long-standing financial instability. We intend to meet remaining commitments to these schools.

Over the years, the health professions student loan program has contributed a total of $420 million to school loan funds for student loans that are interest-free during the training. Federal capital contributions to school loan funds under the nurse student loan program have totalled $298 million.

The need for student financial aid, however, is disproportionately great among under-represented minority groups. To help meet the unusual needs of these students, we propose to provide additional capital contributions to schools with relatively high proportions of minority students.

Using existing revolving funds only, it is estimated that in fiscal year 1985, about $49 million will be available in loan funds for health professions student loans and about $18 million for nursing student loans. It is, however, essential that the school funds be managed so as to maximize the availability of revolving dollars.

Although much can and has been done to reduce delinquency and default rates through administrative actions, several amendments to the legislative authorities for the programs would help assure the continued viability of the loan programs, and I have listed those in my written testimony.

Financially needy health professions students may also borrow under the federally insured Health Education Assistance Loan program. Under the President's budget, we expect that over 20,000 students will be assisted through this program.

Continued expansion of the supply of primary care physicians and the resulting changes in their geographic distribution can be expected to help alleviate much of the nation's medical service needs over the next decade.

Existing programs of financial aid include the family medicine training program, the program of aid to family medicine departments, and the general internal medicine and general pediatric training program. From fiscal 1981 through fiscal 1984 alone, the federal investment in these programs will total over $221 million.

The Federal Government's responsibilities and objectives in the field of health promotion and disease prevention warrant a continued high level of concern for manpower resources in public health.

The administration continues to believe that the most efficient and effective way for the Government to provide support for public health and health administration training is to award funds for special projects to meet high priority national needs.

The AHEC Program—Area Health Education Center Program—addresses national concerns regarding the geographic maldistribution and overspecialization of health professionals by fostering changes in the traditional pattern of health professions education and the educational environment. Many of the earlier AHEC programs are now receiving financial support from State and other non-Federal sources. Of the total number of AHEC programs supported, including the four new ones to be established this year, an estimated eight will require continuing support in fiscal 1985.

As emphasized in the recent IOM report, which both of you gentlemen have referred to, need continues to exist for dealing with special problems relating to the supply, distribution, and utilization of nurses.

A problem of national concern is the extent to which recruitment of minorities and other individuals from disadvantaged backgrounds into the nursing profession has lagged. As of November 1980, only about 7 percent of all registered nurses in the United States were from racial or ethnic minority backgrounds. In recent years, the number of black students enrolled in nursing schools has barely stayed even.

The complexity of today's health care settings demands nurses with specialized knowledge and experience as well as those with managerial skills.

Some specialty nursing shortages have been related to failure to encourage nursing personnel at less advanced levels of training to upgrade their education.

We would continue programs to promote recruitment of nurses from disadvantaged backgrounds, improve the knowledge and skills of nursing personnel, and enhance the effectiveness with which such personnel are utilized, as well as the existing advanced nurse training authority.

The administration's budget for fiscal year 1985 calls for a more modest Federal contribution to nurse training programs than was proposed a year ago in the IOM report. We see the Federal role as serving as a catalyst in enlisting greater support from States, local communities, health care organizations, and professional associations for the improvement of nursing education and practice. We believe the $1.9 billion spent between 1964 and 1984 in Federal support for nursing programs has opened the way for a more highly selective federal presence

Recently, a considerable amount of interest has been generated in the Congress and the nursing community in ways of promoting increased support and greater visibility for nursing research. In mid-1983 I established a task force on nursing research to focus on ways to expand our knowledge about the practice and administration of nursing, as well as strengthening the infrastructure of nursing research.

As you know, the House of Representatives, late last year, passed H.R. 2350, a bill to reauthorize expiring NIH programs. One provision of this bill would require that a National Institute of Nursing be established at NIH. It has been argued that this provision would be an appropriate approach to implementing one of the recommendations of the Institute of Medicine's 1983 report on nursing and nursing education.

As you know, I and the administration are strongly opposed to a National Institute of Nursing at NIH. There are several reasons for this position.

In the first place, the timing is inappropriate. We have requested the Institute of Medicine to conduct a study to develop a rationale and criteria for determining whether the organizational structure of the NIH should be changed.

Second, nursing research is currently well integrated into the structure in which it has been operating.

And, finally, there is considerable consensus that one of the highest priority needs in nursing research is strengthening the research base in schools of nursing and increasing the number of doctorally trained nurse educators and researchers.

If, indeed, the primary consideration is that of accomplishing most effectively and reasonably the goals of furthering the capabilities of nursing research, we need to look at various other approaches to strengthen nursing research in the Public Health Service. Some of the options that we are currently considering include further strengthening of the programs in the Division of Nursing, and changing the current Division of Nursing to a bureau.

Other options are also under review, and I anticipate making a decision by the end of the fiscal year.

While we need flexibility to work out the best possible approach to nursing research in the Public Health Service, I want you to know and I wish to emphasize our willingness to work with you and with the nursing community.

Mr. Chairman, the clear success of our previous investments in health professions education along with the rapidly changing health financing scene means that any health professions reauthorization must contain sufficient flexibility to allow us to take advantage of past successes and future goals.

If all Americans are to have access to high-quality health care at reasonable cost, if we are to promote good health and prevent disease, if we are to return individuals who are acutely ill to good health, and if the quality of life of others is to be improved, we must have an adequate supply of appropriately trained health personnel.

I know that you and members of this committee share this goal, and I look forward to working with you in the coming weeks in the effort to develop mutually acceptable legislative proposals to improve health professions training and practice.

Dr. Graham and I would be happy now to respond to questions.

Thank you.

[The prepared statement of Dr. Brandt and responses to questions submitted by Senators Hatch, Kennedy, Quayle, and Grassley follows:]

STATEMENT BY

EDWARD N. BRANDT, JR., M.D.

ASSISTANT SECRETARY FOR HEALTH

Mr. Chairman and Members of the Committee:

I am happy to have the opportunity to appear before you today to discuss the Administration's views on the proposed extension and amendment of the health professions and nurse training authorities in Titles VII and VIII of the Public Health Service Act, as well as to consider certain issues related to the future role of the Federal Government in the field of nursing research.

Title VII and VIII health professions and nurse training programs date back to the mid-1960's, when the Federal Government first recognized a broad national concern for the extent to which the Nation's needs for physicians, dentists, nurses, and certain other health professionals were being met. In the early years of the programs, the primary emphasis was on expanding overall supply of personnel. Since the late 1970's, the focus has been on improving the distribution of personnel by specialty and geographic location, facilitating access to training for students from disadvantaged groups, and other more targeted purposes.

Shortages of specific types of health professionals in particular locations or settings continue to exist. Opinions differ on the exact dimensions of the shortages and how best to remedy them.

Traditionally, State and local governments, health professions schools, professional organizations, and other non-Federal groups have taken a major responsibility for the solution of problems of health professions education and practice. The Administration believes that these non-Federal groups should continue to play a central role in this field. The Federal Government should support and stimulate non-Federal activities as needed to accomplish national health goals. The appropriate functions for the Public Health Service must be carefully defined.

In considering reauthorization of the health professions and nursing authorities for fiscal year 1985 through 1987, we have assumed that the Public Health Service will continue to provide leadership in defining directions and anticipating needs, primarily through information gathering, selective financial aid, and technical assistance. Rising costs as well as the need to assure high quality health services call for efforts by all sectors at all levels to cooperate in solving mutual health personnel problems.

Mr. Chairman, the Administration's highest priority in the health professions field at this time is to increase the numbers and improve the capability of health care providers serving minority and underserved populations. Other major objectives include promoting a sufficient supply of primary care physicians, strengthening training in health promotion and disease prevention, supporting certain other health professions initiatives, and improving the training and utilization of nurses. Our reauthorization proposal addresses these objectives.

Serving the Disadvantaged and Minorities

Increasing the numbers and capability of providers serving minority and disadvantaged populations can be accomplished in part by recruiting more health professionals from among these groups. Evidence indicates that health professionals from minority and disadvantaged backgrounds are more likely than individuals from other types of backgrounds to provide care to the underserved. We also must improve the preparation of practitioners generally (from disadvantaged and other backgrounds alike) to provide care for underserved groups.

Despite some advances in recent years in providing for equity of access to health professions careers for individuals from economically disadvantaged and minority groups, recruitment of such individuals continues to lag. Looking ahead, rising tuition costs, competing opportunities in other fields, and continuing problems with pre-professional education can be expected to sustain the need for special recruitment efforts for disadvantaged students.

Federal initiatives to provide educational assistance to health professions students from disadvantaged backgrounds have been vigorously pursued since the early 1970's. Funds have been awarded through grants and contracts to health or educational entities to support the identification, motivation, recruitment, admission, retention, and placement of minority and disadvantaged students. Measurable progress has been made; for example, medical schools aided under this program have increased minority enrollment more than have medical schools not so assisted. Much remains to be done. The Administration proposes to fund the disadvantaged assistance program at $24 million in fiscal year 1985—about one-third higher than the current level of $18.2 million.

Certain predominantly minority health professions schools have played a special role in training individuals from disadvantaged and minority backgrounds. The Advanced Financial Distress authority, established in fiscal year 1982, has permitted multi-year support to selected schools to the extent essential to remove these schools from serious and long-standing financial instability. The Department recognizes the need to continue to assist and ensure the operation of the four eligible schools: Meharry School of Medicine, Meharry School of Dentristry, Tuskegee Institute School of Veterinary Medicine, and Xavier University College of Pharmacy. We intend to meet remaining commitments to these schools and to extend for one additional year the time allowed for the schools to achieve financial solvency.

From the inception of the Federal health professions and nursing programs, support has been provided for low-cost loans to students in need of such assistance to complete their training. Over the years, the Health Professions Student Loan program has contributed a total of $420 million to school loan funds for student loans that are interest-free during the training and subject to a below-market rate of interest during a 10-year repayment period. Federal capital contributions to school loan funds under the similar Nursing Student Loan program have totaled $298 million.

Need for student financial aid is disproportionately great among health professions students from underrepresented minority groups, particularly students in medical school or comparably lengthy and expensive training programs. To help meet the unusual needs of these students, the Administration proposes to provide additional capital contributions to schools with relatively high proportions of minority students. The total amount requested for this purpose in fiscal year 1985 is $5 million.

Because the Health Professions and Nursing Student Loan programs operate on a revolving-fund basis, with amounts repaid by earlier borrowers becoming available for loans to new borrowers, it has been possible to reduce the amount of new Federal capital contributions in recent years. Using revolving moneys only, it is estimated that in fiscal year 1985, about $49 million will be available in school loan funds for Health Professions Student Loans to about 24,500 students, and about $18 million, for Nursing Students Loans to about 22,400 students. We favor allowing these funds to continue circulating.

With the Health Professions and Nursing Student Loans funds now largely dependent on repaid loans as a source of money for new loans, it is essential that the school funds be managed so as to maximize the availability of revolving dollars. You are aware that there have been certain problems of loan collection under these programs. Although much can and has been done to reduce deliquency and default rates through adminstrative actions, several amendments to the legislative authorities for the programs would help assure the continued viability of the loan programs. Among the amendments we seek are a change in the Internal Revenue Code to allow release of taxpayer addresses, a requirement for increased penalties for late payment, and provisions allowing a school to refer a loan to the Federal government for collection assistance, but only after the school has exercised diligence in attempting to recover the funds.

Financially needy health professions students, as well as those who are not from economically disadvantaged groups, may also borrow under the Federally insured Health Education Assistance Loan (HEAL) program. These loans are not

Government-subsidized; borrowers pay interest at market rates throughout the life of the loans and must pay an insurance premium to cover defaults due to death, disability, or other causes. The fact that the loans are Federally insured does assist needy students in locating private lenders who are willing to make loans to cover educational costs. Under the President's budget we expect that over 20,000 students will be assisted through this program.

To improve the preparation of health professionals generally to provide care for disadvantaged minority groups and underserved populations, the Government has helped train primary care personnel, whose services are particularly needed in underserved areas, and promoted the development of training resources in locations remote from existing medical centers, among other efforts. The primary care training programs will be discussed in a separate section of this statement; they relate to broader problems of supply of physician specialists. One mechanism for developing training in remote areas has been the area health education center (AHEC) program. The AHEC program is discussed under the section on other health professions initiatives below.

Primary Care Physician Training

Continued expansion of the supply of primary care physicians and the resulting changes in their geographic distribution can be expected to help alleviate much of the Nation's medical service needs over the next decade. Accordingly, the need for direct Federal subsidies has declined considerably. Needs, however, will persist in many currently designated shortage areas. The recent increase of family practitioners nationwide has already had a positive effect, but has not yet brought about a fully adequate supply of physicians for the smaller towns and certain inner-city neighborhoods.

Existing programs of financial aid for primary care physician training include the family medicine training program, the program of aid to family medicine departments, and the general internal medicine and general pediatric training program. From fiscal year 1981 through fiscal year 1984 alone, the Federal investment in these programs will total over $221 million. We do believe, however, that primary care training programs can reasonably be expected over the next few years to support an increasing proportion of their costs from non-Federal sources.

Training in Public Health

The Federal Government's responsibilities and objectives in the field of health promotion and disease prevention warrant a continued high level of concern for manpower resources in public health. Adequately trained public health professionals, effectively utilized, are essential to progress in prevention of disease, identification and control of environmental health hazards, among other national priority health goals.

Types of specialists for which need continues to exist include:

-- epidemiologists knowledgeable about non-infectious disease, new-generation infectious disease, and environmental problems;

-- environmental health professionals skilled in toxicology, assessment of risks related to hazardous chemical and physical agents, and other specialty areas;

-- public health nurses, nutritionists, and health educators prepared to address problems of children, the aged and the disadvantaged.

In the field of health administration, changing patterns of organization and practice are creating needs for new types of skills. For example, with the growth of health maintenance organizations has come a demand for individuals capable of successfully managing such organizations.

The Administration continues to believe that the most efficient and effective way for the Government to provide support for public health and health administration training is to award funds for special projects to meet high priority national needs. We would permit use of project funds both for training support and for traineeships to students. The Government and the schools would have maximum flexibility in determining the fields of study requiring priority attention and the types of students for whom recruitment incentives are necessary. The fiscal year 1985 budget request allows continued Federal stimulation for efforts to increase the supply of adequately trained preventive medicine specialists.

Other Health Professions Special Initiatives

As health problems and ways of dealing with these problems change, different needs arise with respect to education and practice of health professions personnel. For example:

- Training in geriatric and long-term care is required on the basis of the drastically increasing number of elderly persons who will populate this country by the year 2000.
- Teaching of health professionals about cost containment is needed in an era of rising health care costs and increasing public interest in health financing reforms.

- Innovative ways of improving the competency of existing faculty in health professions schools, as well as recruiting new faculty, at a time of fiscal constraints, need to be explored.

To facilitate rapid and appropriate response to emerging requirements for Federal financial assistance to State, local, and voluntary entities in efforts to meet new health professions needs, it is important that there be a general authority for health professions special projects.

The AHEC program addresses national concerns regarding the geographic maldistribution and over-specialization of health professionals by fostering changes in the traditional pattern of health professions education and the educational environment. The program provides funds to health professions schools for the purpose of decentralizing education, with portions of training provided in shortage areas. Since the establishment of the program in the early 1970's, a total of 23 statewide, rural, and urban projects have received support. Four new programs are scheduled to be established in fiscal year 1984.

A major objective of the AHEC program is to institutionalize changes in health professions education designed to meet the needs of underserved areas through State and local initiatives. There is strong evidence that the program has been a success in achieving local support. Many of the earlier AHEC programs are now receiving financial support from State and other non-Federal sources. Of the total number of AHEC programs supported, including the four new ones to be established this year, an estimated eight will require continuing support in fiscal year 1985.

Improvement of Nurse Training and Utilization

As emphasized in the recent Institute of Medicine report, "Nursing and Nursing Education: Public Policies and Private Actions," need continues to exist for dealing with special problems relating to the supply, distribution, and utilization of nurses. Despite a projected adequate national aggregate supply of generalist nurses, there are shortages in particular geographic areas, specialties, health care institutions, and types of practice. The Federal Government is joining with other public and private bodies in seeking to resolve these shortages.

A problem of national concern is the extent to which recruitment of minorities and other individuals from disadvantaged backgrounds into the nursing profession has lagged. As of November 1980, only about 7 percent of all registered nurses in the United States were from racial/ethnic minority backgrounds. In recent years, the number of Black students enrolled in nursing schools has barely stayed even.

Changing health problems and care delivery patterns require new approaches in the content of nursing education. For example, the elderly need hospital, nursing home, and home care services more than do other segments of the population. Another type of curriculum improvement for which support is needed is the strengthening of education in various methods of promoting health and preventing disease.

The complexity of today's health care settings demands nurses with specialized knowledge and experience as well as those with managerial skills. This is particularly true in acute-care settings where technological advances have had the greatest impact on patient care. Other types of nurse specialists in short supply are those prepared for service in community nursing positions, as faculty in nursing education programs, and as administrators of nursing service.

Some specialty nursing shortages have been related to failure to encourage nursing personnel at less advanced levels of training to upgrade their education. For example, RNs trained in associate degree and diploma schools can obtain baccalaureate education, thus enlarging the pool of individuals able to assume increased nursing care responsibilities and, as appropriate, enter graduate-level education programs.

We would continue programs to promote recruitment of nurses from disadvantaged backgrounds, improve the knowledge and skills of nursing personnel, and enhance the effectiveness with which such personnel are utilized, as well as the existing advanced nurse training authority to expand and strengthen programs for the training of professional nurses as teachers, administrators, supervisors, or other nursing specialists.

The Administration's budget for fiscal year 1985 calls for a more modest Federal contribution to nurse training programs than was proposed a year ago in the Institute of Medicine report. We see the Federal role as serving as a catalyst in enlisting greater support from States, local communities, health care organizations, and professional associations for the improvement of nursing education and practice. We believe that the $1.9 billion spent between 1964 and 1984 in Federal support for nursing programs has opened the way for a more highly selective Federal presence over the next few years.

Nursing Research

Recently, a considerable amount of interest has been generated in the Congress and the nursing community in ways of promoting increased support and greater visibility for nursing research. In mid-1983, I established a Task Force on Nursing Research to focus on ways to expand our knowledge about the practice and administration of nursing as well as strengtheing the infrastructure of nursing research. In the course of their deliberations, the members of the Task force met with many nurses representing various avenues of nursing research. As an adjunct to this effort, NIH is considering nursing research from its perspective.

As you know, the House of Representatives late last year passed H.R. 2350, a bill to reauthorize expiring NIH programs. One provision of this bill would require that a National Institute of Nursing be established at NIH. It has been argued that this provision would be an appropriate approach to implementing one of the recommendations of the Institute of Medicine's 1983 report on Nursing and Nursing Education. Specifically, the IOM noted that "An adequately funded focal point is needed at the National level to foster research that informs nursing and other health care practice and increases the potential for discovery and application of various means to improve patient outcomes." It seems clear from the language of this recommendation that the organizational entity that could best fulfill this need would be one where maximum emphasis is placed on health care delivery research.

As you know, I am strongly opposed to a National Institute of Nursing at NIH. There are several reasons for my position:

- The timing is inappropriate; the Department has requested the Institute of Medicine to conduct a study which, among other things, is developing a rationale and criteria for determining whether the organizational structure of the NIH should be changed to any substantive extent and the findings will be considered in the context of current and anticipated scientific developments and economic considerations.

- Nursing research is currently well integrated into the structure in which it has been operating and any significant changes would be disruptive. The Division of Research Grants at NIH refers proposals to the appropriate operational entity for review. For example, proposals that are biomedically-oriented are reviewed at NIH and ADAMHA, and those that relate to nursing practice or administration are reviewed in the Division of Nursing at HRSA. Special problems of mutual interest are carried out jointly, such as those being carried out with the Division of Nursing and the National Institute on Aging.

- There is considerable consensus that one of the highest priority needs in nursing research is strengthening the research base in schools of nursing and increasing the number of doctorally trained nurse educators and researchers. This could best be accomplished in programs closely aligned to nurse training and education.

If indeed the primary consideration is that of accomplishing most effectively and reasonably the goals of furthering the capabilities of nursing research, appropriate administrative and cost considerations, we need to look at various other approaches to strengthen nursing research in the Public Health Service. The options that we are currently considering include:

- o Further strengthening of the programs in the Division of Nursing in the Bureau of Health Professions (including the nursing research function);
- o Changing the current Division of Nursing to a Bureau.

Other options are also under review, and I anticipate making a decision by the end of the fiscal year.

In addition to these organization/administrative options that are under review, we are also reassessing within the context of existing Public Health Service resources our budgetary needs in nursing research. While we need flexibility to work out the best possible approach to nursing research in the Public Health Service, I would like to emphasize our willingness to work with you and the nursing community.

Conclusion

In considering the reauthorization of the health professions training programs, we are truly at a watershed in the history of Federal support. Over the last quarter of a century, Congress and previous administrations have supported over $20 billion through HHS, VA, and DOD to greatly expand the numbers of and access to health professionals. As I have discussed above, there is ample evidence of success in such areas as the National Health Service Corps, which is working toward achieving its goal of reducing the number of medically underserved areas. With regard to health financing, the expansion of HMO's and PPO's, implementation of prospective payments for Medicare, use of Medicaid waivers, and evidence of greater competition among the increasing supply of physicians, we clearly are in the midst of a rapidly changing health care delivery system.

The clear success of our previous investments along with the rapidly changing health financing scene means that any health professions reauthorization must contain sufficient flexibility to allow us to take advantage of past successes and future opportunities.

Mr. Chairman, if all Americans are to have access to high quality health care at a reasonable cost, if we are to promote good health and prevent disease, if we are to return individuals who are acutely ill to good health, and if the quality of life of chronically ill or disabled persons is to be improved, we must have an adequate supply of appropriately trained health professionals. I know that you share this goal and I look forward to working with you in the coming weeks in the effort to develop mutually acceptable legislative proposals to improve health professions training and practice. I would be happy to answer any questions you may have.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

MAY 7 1984

Mr. Ron Docksai
Staff Director
Committee on Labor and
Human Resources
Senate Dirksen, Room 428

Dear Mr. Docksai:

Enclosed are the responses to questions asked of Dr. Brandt at your reauthorization hearing for the health professions education and nurse training programs.

Ed
Ed McGroarty
Legislative Officer

Enclosures

Senator Hatch. I understand the Administration conducts an ongoing assessment of "manpower" needs, and that projections based on your data do not indicate as many excess health providers as the GMENAC Report. How do you account for the differences in projected needs?

Dr. Brandt. There are several important methodological differences between the Department's projections and those developed by the Graduate Medical Education National Advisory Committee. The Department's projections represent a continuation of past trends, on the basis that the demand for medical care is likely to continue to grow in the future, but at a slower rate that it has in the past. In this respect, the Department's projections are similar to those provided by the Bureau of Labor Statistics of the Department of Labor.

The GMENAC projections are much more normative. They represent the views of a panel of experts on how people should consume care and how the health care sector should provide this care.

While significant differences exist between these two approaches, both sets of projections indicate that physicians and other health professionals will be in a more competitive situation than exists at the present time.

Q. Senator Hatch. The Administration has proposed cutting funding for family medicine and general internal medicine and pediatric training programs. However, several studies have pointed out that these primary care residency programs are unable to generate their training costs, as long as reimbursement policies favor paying for diagnostic and surgical procedures. Do you think the Federal Government should continue to support these programs?

A. Dr. Brandt. The Administration proposes to continue to support primary care physician training at a somewhat reduced level.

Since 1972, Federal funds have assisted in a rapid expansion of accredited allopathic family practice residency programs from 107 programs with 500 first-year positions to 386 operational programs with 2,600 first-year positions.

The FY 1985 funding authorization would provide partial support to 249 family medicine training projects, impacting approximately 11,900 residents and trainees. Funding includes support at the predoctoral and graduate level (internship and residency) for both allopathic and osteopathic programs as well as assistance for faculty development for physicians who plan to teach in family medicine.

The proposed reduction in Federal funding is consistent with the Administration's effort to focus limited available Federal health professions funds on the highest priority national needs.

Q. Senator Hatch. Given the popularity of physician assistants in our current health care system and their capacity to provide economic primary care services in underserved areas, why has the Administration proposed zero funding for these training programs?

A. Dr. Brandt. From FY 1972 through FY 1984 the Department will have expended approximately $93.2 million for the training of physician assistants. Most of these programs are mature. Those stable programs which have not received Federal funds in recent years have been able to secure support from either State or other sources to maintain operation. The PA program has been very successful in reaching its long-range goals; the Department projects that the number of practicing physician assistants will increase to 22,100 by 1990. Concurrently, there is projected to be an adequate aggregate supply of physicians. We expect that through natural market forces, many of these physicians will provide services in underserved areas. The decision not to extend the physician assistant training authority is consistent with the Administration's policy of directing Federal expenditures, at a time of fiscal constraints, to the highest priority national needs.

Senator Hatch. As you know, the cost of education in health professional schools has increased dramatically over the past few years. Some have suggested that soon only the children of the rich will be able to become doctors and dentists and that qualified students are turning away from health careers because of the costs. Do you think current student loan programs are sufficient, or should we explore new methods of financial aid for students who wish to become health professionals?

Dr. Brandt. For financially needy health professions students there are several low-interest loan programs, including the Health Professions Student Loan Program, the National Direct Student Loan Program, and the Guaranteed Student Loan Program. Under each of these programs, the student pays no interest while he or she is still in training. During the repayment period, interest is charged at below-market rates.

Because need for student aid is disproportionatly great among health professions students from underrepresented minority groups, the Administration has proposed that limited Health Professions Student Loan appropriations be authorized for additional capital contributions to schools with relatively high proportions of minority students. The total amount authorized for this purpose in fiscal year 1985 would be $5 million.

Students who find it necessary to work in addition to attending school may receive assistance under the Department of Education's College Work-Study Program.

If other resources are not available, the Federally insured Health Education Assistance Loan (HEAL) Program assists health professions students in obtaining market-rate loans from non-Federal lenders.

Upon completing their training, health professionals normally earn enough to repay their loans over a period of time.

Q.5. Dr. Brandt, I would like you to comment further on the Department's Task Force on Nursing Research. Could you give us some specific examples of the activities they have been involved in?

Answer: The Task Force on Nursing Research, a Public Health Service effort, has undertaken several activites in order to gain additional insight from the nursing community on nursing research. These activities have included:

- Numerous contacts with a broad spectrum of nurses involved in the academic community, hospital quality assurance departments, pharmaceutical companies and others for the purpose of discussing nursing research.
- A meeting with the leadership of the Tri Council for Nursing to discuss reauthorization of Title VIII of the PHS Act and the Tri Council's Support for a National Institute of Nursing Research. The Tri Council represents the American Association of Colleges of Nursing, the National League for Nursing and the American Nurses Association.
- A meeting in Philadelphia with Dr. Claire Fagin, Dean of the University of Pennsylvania School of Nursing as well as the school's principal nurse educators and researchers to address nursing research needs and ideas.
- A telephone consultation with Dr. Ruby Wilson, Dean, Duke University School of Nursing representing the Virginia/Carolinas Doctoral Consortium in Nursing.
- Follow-up discussions on child health issues and nursing research with the National Association of School Nurses, Inc., Child Health Advocacy Council.

It has also been reported to us that a task force on nursing research has been convened at NIH. Has such a task force been developed and if so could you report to us on their activities?

As an adjunct to the Public Health Service (PHS) Task Force, an NIH Task Force on Nursing Research was established by the National Institutes of Health (NIH) Director in March 1984. The examination by this group, of NIH-related nursing research activities, is an essential component of PHS deliberations concerning nursing research, training, and education. Chaired by Dr. T. Franklin Williams, Director of the National Institute on Aging, the NIH task force will look at past, current, and potential future support of nursing research consistent with the NIH mission. The task force is currently being organized, and its initial meeting will be held shortly. A report to the NIH Director, which will be transmitted to PHS, will be due in six months.

Senator Hatch. Could you describe for the Committee the problems relating to the nursing student loan proposed regulation changes and what the Department is doing to correct the problems?

Dr. Brandt. The Department is currently developing the final NSL program regulations. Among the issues being analyzed are the acceptable rate of delinquency and the formula by which this delinquency rate will be calculated. In determining an acceptable level of delinquency, it should be noted that at time of repayment a nursing borrower who graduates is comparable to other borrowers who borrow from commerical lending institutions. In preparation of the final regulations, the Department is attempting to keep pressure on the schools to aggressively pursue the collection of their NSL funds, and to allow as many schools as possible to continue participating in the NSL program. Dates for compliance with the performance standard will be predicated upon the date of publication of the final regulations.

Senator Grassley. I was struck by your comment to the effect that more geriatric training is needed in view of the increasing number of elderly people in the country. I hear a lot about this, of course, as Chairman of the Subcommittee on Aging of this Committee. Can you tell us a little more about how the programs we are considering today will be used to help increase the number of health practitioners who are familiar with geriatric dimensions of medical problems?

Dr. Brandt: The most targeted support for geriatric training of health professionals is being provided under section 788(b) of the PHS Act, which is a general authority for special initiatives relating to health professions training and practice. Four geriatric education centers were funded by the Bureau of Health Professions in FY 1983 to provide comprehensive services to the health professions educational community within designated geographical areas over a three-year period. Efforts of the four centers involve planning and delivery of a wide range of services to health professions education programs. These services include: the preparation of faculty to teach geriatrics in medicine, osteopathy, dentistry, pharmacy, nursing, social work, and other training programs; the provision of technical assistance in the design and conduct of inservice and continuing education programs for practicing health professionals, and assistance to health professions schools in the selection, installation, implementation and evaluation of appropriate geriatric course materials and curriculum, improvements. All of these activities will serve to extend a geriatric training focus to a greater number of health practitioners.

In addition, the Bureau of Health Professions allows and encourages expenditure of funds under various categorical training authorities, including nursing, family medicine, general internal medicine and pediatrics, and area health education center training authorities, for curriculum elements related to geriatrics and gerontology.

Senator Grassley: You mentioned a task force on nursing research. Has this task force completed its work, and, if so, is a report available?

Dr. Brandt: The Task Force on Nursing Research, a Public Health Service effort, has not issued a report but has undertaken several activities in order to gain additional insight from the nursing community on nursing research. These activities are ongoing and thusfar have included:

- ° Numerous contacts with a broad spectrum of nurses involved in the academic community, hospital quality assurance departments, pharmaceutical companies and others for the purpose of discussing nursing research.
- ° A meeting with the leadership of the Tri Council for Nursing to discuss reauthorization of Title VIII of the PHS Act and the Tri Council's Support for a National Institute of Nursing Research. The Tri Council represents the American Association of Colleges of Nursing, the National League for Nursing and the American Nurses Association.
- ° A meeting in Philadelphia with Dr. Claire Fagin, Dean of the University of Pennsylvania School of Nursing as well as the School's principal nurse educators and researchers to address nursing research needs and ideas.
- ° A telephone consultation with Dr. Ruby Wilson, Dean, Duke University School of Nursing representing the Virginia/Carolinas Doctoral Consortium in Nursing.
- ° Following-up discussions on child health issues and nursing research with the National Association of School Nurses, Inc., Child Health Advocacy Council.

Senator Grassley. You mentioned that nursing research is currently well integrated into the NIH structure and that any changes would be disruptive. Yet I think that the witnesses who follow you on the nursing panel will maintain that funding for nursing research through the present structure has not been very substantial. Can you comment?

Dr. Brandt. Support for nursing research has had to compete with other priorities on the Nation's health agenda. However, as I pointed out in my testimony, we are reassessing our budgetary needs in nursing research within the context of existing Public Health Service resources.

Senator Grassley. Can you tell us a bit more about what you have in mind when you say that non-Federal groups should play a central role in health professions education?

Dr. Brandt. Throughout the Nation's history, the responsibility for educational programs in the United States has belonged primarily to State, local, or voluntary groups. The Federal Government has provided support or taken other initiatives as required to help assure equitable access to educational opportunities and to address other high priority national needs that can not be met by non-Federal groups alone. In the case of health professions education, the Federal role consistently has been one of providing assistance or stimulus to non-Federal activities. With recent increases in overall supply of health professionals, we believe that non-Federal groups can continue to assume major responsibility for seeking solutions to remaining problems of supply and distribution of adequately trained personnel.

Senator Quayle. Given the changes which are occurring in the relative age of our population and the rather lengthy pipeline for physician training, what specific plans are in place or would you suggest to insure that we are prepared to deal adequately with our aged?

Dr. Brandt. Requirements for education and training of health professionals in geriatrics and gerontology are expected to grow with the health care needs of an expanding elderly population. At the direction of the House Appropriations Committee, a Report to Congress on Education and Training in Geriatrics and Gerontology was recently prepared by the Department. I called upon Dr. T. Franklin Williams of the National Institute on Aging to coordinate development of this report which contains a plan of action to improve and expand training in geriatrics and gerontology in FY 1984 and beyond through activities supported by the Health Resources and Services Administration, the Administration on Aging, the National Institute of Mental Health and the National Institute on Aging. An Ad Hoc Committee comprised of representatives of the above agencies and representatives of the Veterans Administration, the Department of Defense and the National Institutes of Health was established to guide development of the report. Comments and advice of experts on education and training and of health, mental health and social services organizations involved in aging were obtained in developing the plan.

Submitted to Congress on February 28, 1984, the plan outlines five objectives and related activities that would contribute to the goal of improving and expanding education and training in geriatrics and gerontology for health professions. One of these objectives is to make available information of the status and effectiveness of education and training activities in geriatrics and gerontology. Several such efforts are now underway, supported by Title VII authorities. The Bureau of Health Professions is conducting surveys to assess the status of geriatric curricula for several of the health disciplines, including nursing, pharmacy and podiatry. In addition, an evaluation of the effects of grants awarded in 1978-80 to develop and implement interdisciplinary geriatric curricula is underway. Results of these efforts will provide some baseline information regarding the extent and nature of professional preparation in geriatrics and gerontology at the present time, enabling more efficient direction of training resources for this purpose in the future.

Another objective outlined in the plan is to expand and integrate geriatrics and gerontology in basic health professional education programs. Under Sec. 788(b) of the Public Health Service Act, in October 1983, the Bureau of Health Professions awarded $871,734 to establish four regional geriatric education centers for the training of multidisciplinary faculty (including medicine, dentistry, nursing and social work, along with other disciplines such as pharmacy, occupational and physical therapy and clinical psychology), the development of geriatric curricula and continuing education materials, and to serve as geriatric information resource centers within their designated geographic areas. The establishment of additional geriatric education centers would extend the provision of this training and service beyond the 11 States that will be reached by the four centers funded in October.

Senator Quayle. In several of the health professions loan programs federal funds were used to capitalize revolving loan funds. During the past few years, however, capitalization has been seriously reduced or eliminated completely. Further, the requirements of Titles VII and VIII do not currently allow redistribution of excess loan funds or funds returned by virtue of academic program terminations. Given that a) programs fluctuate in terms of student numbers, b) academic programs change, c) institutions initiate new programs, and d) the costs of education have increased dramatically, doesn't it therefore seem necessary to provide some mechanism in these loan programs to deal with these changes? If not, the availability of loan funds in this year is dependent on fund distributions which occurred between 1975 and 1981 and do not necessarily reflect the current distribution of students and programs. Do you have solutions to this problem?

Dr. Brandt. The Administration is particularly concerned about the need for further capitalization of loan funds of health professions schools that have relatively high proportions of minority and disadvantaged students. We have requested authorization of additional funds to be distributed to schools with significant enrollments of students from under-represented minority groups (Black, Hispanic, American Indian and Mainland Puerto Ricans). Of the $5 million authorized for appropriation in FY 1985, $2.5 million would be allotted among the 10 schools having at least 50 percent underrepresented minority enrollment. The remaining $2.5 million would be allotted to schools having at least 10 percent underrepresented minority enrollment (estimate: 52).

In addition, to allow moneys that otherwise would be lost to the Health Professions and Nursing Student Loan programs to be used to augment the loan resources of schools having special need for additional funds because of their newness to the program or other reasons, we favor amendments to provide that any excess cash or other moneys returned to the Secretary from school loan funds be allowed to be allotted among participating schools in such manner as the Secretary determines will best carry out the purposes of the programs. In fiscal year 1983, approximately $4.7 million was received from school loan funds (health professions and nursing) as "excess cash." An additional $2.4 million was returned by schools whose loan programs were terminated.

Senator Quayle. The Administration shares with the Congress the goal of increasing minority and disadvantaged student access to a medical education. The budget recommendation of the Administration, however, proposes the elimination of the Exceptional Financial Need Scholarship Program and substitutes a loan program at a lower overall level. Is there evidence that a loan program can achieve the goal of the original scholarship program?

Dr. Brandt. The Department has carefully reviewed the extent to which the funds appropriated for the EFN program cover the needs of minority and disadvantaged students, and has found the the EFN program does not make the best use of these funds, since this program assists only a minimal number of students on a one-time basis. In place of the EFN program, the Department is proposing to allocate an approximately equal amount of funds for additional low-interest health professions students loans for minority and disadvantaged students. This would maximize the use of these funds by making them available to a greater number of students in their initial allocation. Also, the funds could be reloaned to additional needy students in future years.

Senator Kennedy. It is my understanding that there is some concern within the Department about an increasing default rate projected for the HEAL loan program. Some people are suggesting charging students even more than the current 2% default insurance rate. Since this proposal would increase the cost of the HEAL loan to the students, most of whom will not be in default, could you suggest other possible solutions to the anticipated default problem?

Dr. Brandt. Currently the HEAL insurance fund is solvent and we expect it to remain so through FY 1985. Legislative proposals have been drafted to protect the insurance fund's solvency by allowing the insurance premium paid by students to be increased. In addition, the Department is reviewing the possibility of changing the method of calculating the insurance premium in order to assure long term solvency. Currently the insurance premium is charged for the in-school and grace period only. The Department is considering the possibility of charging an insurance premium over the life of the loan. Our first preference, however, would be to reduce the loan default rate. Although HEAL interest rates are somewhat higher that those of the Health Professions Student Loan program and the Department of Education's Guaranteed Student Loan program, we believe that most students are borrowing prudently and should be able to meet their loan repayment obligations.

Senator Kennedy. In your testimony you state that some specialty nursing shortages have been related to failure to encourage nursing personnel at less advanced levels of training to upgrade their education. However, in the Administration's budget, funding for advanced nurse training would be drastically cut from $13 million in FY 1984 to $1 million in FY 1985 and funding for nursing traineeships and nursing fellowships would be completely eliminated. With such dramatic cuts in funding, how do you expect nurses to pursue advanced training?

Dr. Brandt. The reduction in support for advanced nurse training reflects the need to continue to address high priority program requirements with limited resources. Constraints on Federal spending also dictate the need for eliminating student support, particularly for individuals who can finance their education through part of full time employment as registered nurses.

Senator Kennedy. In your testimony you state that recruitment of individuals from economically disadvantaged and minority group backgrounds continues to lag despite some advances in recent years. Furthermore, you admit that rising tuition costs, competing opportunities in other fields, and continuing problems with pre-professional education can be expected to sustain the need for special recruitment efforts for disadvantaged students. However, the Administration's budget proposal calls for the elimination of the Exceptional Financial Need Scholarship program, to be replaced by a loan program for the disadvantaged student. The new loan program would be funded at a level that is $600,000 less than the previous Exceptional Financial Need Scholarship program's $5,600,000. Do you believe that this new program at the lower funding level will meet the needs of the economically disadvantaged and minority group students?

Dr. Brandt. The Exceptional Financial Need Scholarship program has assisted a relatively small number of exceptionally needy health professions students in meeting the costs of the first year of professional training. From an appropriation of $5.6 million in FY 1984, an estimated 357 recipients will receive scholarships averaging $15,655. The proposed $5 million in additional capital contributions to Health Professions Student Loan, together with the school's approximately $600,000 in required matching dollars, would provide loans at the current average of $2,000 per borrower to about 2,800 students. Also, these funds would be repaid to school loan funds and become available for reloaning to future borrowers.

Senator Kennedy. For the past three years, the Administration has proposed funding levels for nursing education which are significantly below both the recommendations of the Institute of Medicine, and the level ultimately adopted by the Congress. In light of such clear evidence that funding for these programs should be well in excess of your request, how do you justify yet another unreasonably low funding level of $14 million for FY 1985?

Dr. Brandt. The Administration proposes to refocus Federal health professions and nursing programs so as to increase educational opportunities for the economically disadvantaged and minorities; to increase the number of health care providers for underserved populations; and to support national priority projects. To this end, and within the total resources allowed, we are supporting nurse training programs that serve the new effort.

Aggregate nurse supply and demand are now, and will be for the remainder of the decade, in reasonable balance. Federal support should be targeted to areas which are amenable only to Federal intervention and to areas in which Federal actions can serve as a catalyst to the non-Federal sector. States, local governments, and private groups should assume primary responsibility for the broad range of activities related to maintaining a balance between supply and requirements for registered nurses.

The Administration's legislative proposals address the IOM recommendations in support of advanced nurse training, nurse practitioner training, and certain initiatives such as fostering collaboration between nursing education and nursing service, strengthening the geriatric content of nursing education programs, and promoting strategies to recruit minority and nontraditional students into nursing.

Q. Senator Kennedy. Dr. Brandt, over the past decade, we have seen a rapid growth in the number of medical school graduates entering primary care residency programs. This has occurred despite the fact that primary care physicians earn substantially less than sub-specialtists and other non-primary care physicians. Indications are that, if we maintain existing levels of production, we will have a sufficient supply of family physicians, general internists, and pediatricians by 1990. However, the Administration proposes to cut the funding for primary care training by $30 million to a level that is a little more than half of the FY 1984 levels. Do you think that the primary care/family medicine residencies will be able to continue without Federal funding? If so, which non-Federal sources will support these programs?

A. Dr. Brandt. Due to the clear success of two decades of Federal financial assistance, a sufficient aggregate supply of primary care physicians is expected by 1990. To help solve remaining problems of specialty and geographic distribution, the Administration would continue to support family medicine and general internal medicine and pediatrics training at a somewhat reduced level. Training institutions would be called upon to support an increased proportion of their costs from non-Federal sources.

The extent to which funding may be available for education from reimbursement for patient care costs will depend on the outcome of current debates on reimbursement policies. Other principal sources of support are State and local governments. Through ongoing technical assistance to applicants and grantees, Federal staff continuously stress the need for primary care programs to become institutionalized. Similarly, this concept is emphasized at pertinent professional meetings and in the review process when competitive proposals are being evaluated.

Q. Senator Kennedy. Dr. Brandt, the Administration's budget proposal for FY 1985 requests a 50% reduction in funding for training in preventive medicine. In your testimony, you state as one of your major objectives the strengthening of training in health promotion and disease prevention. However, instead of the $2 million that are authorized by the existing Title VII and appropriated in FY 1984, the Schools of Medicine, Osteopathy, and Public Health will have to compete for only $1 million. Prevention is critical to this nation, in terms of better health for its citizens and a better quality of life for Americans, thus, the need for preventive medicine residencies is important. What is the justification for cutting back this small but important program? Is this another example of the rationale that the states will make up the difference or that the private sector will somehow step in to protect the public health?

A. Dr. Brandt. The Administration has a significant interest in the development of educational systems needed to produce physician manpower required to sustain the Federal initiatives in health promotion/disease prevention. However, the proposed funding reduction must be viewed in the context of the continuing need to restrain Federal spending.

The grant program is not specifically designed to increase resident production through direct funding, but rather to serve as a catalyst for growth in the field of health promotion/disease prevention. It is expected that the increased strength of the programs as a result of Federal support will place them in an improved position to obtain resources necessary for continued operation at an expanded level.

The Administration's budget proposal for FY 1985 includes a request to continue support at the current level for a grant program to train allied health personnel in health promotion and disease prevention. The nine funded training centers focus on allied health occupations in which practitioners are able to influence treatment options and patient behavior and can provide individual client services through personal intervention.

The FY 1985 request also proposes $2,000,000 to support a new program which would concentrate on shortages of specialized public health personnel required to address high priority national health initiatives identified in "Promoting Health/Preventing Disease: Objectives for the Nation." This new program would be targeted to improve curricular content, to develop faculty and to provide more accessible training to the current work force in high priority areas such as environmental health, occupational health, epidemiology, nutrition and health administration.

Senator Kennedy. Dr. Brandt, the Administration's budget proposal for FY 1985 requests only $2 million for public health training; this represents a $7 million reduction from FY 1984. Since the graduates of the schools of public health work primarily in the public sector in the areas of disease prevention and health promotion, and since these graduates represent the basic resource pool from which Federal, State, and local health and environmental agencies draw their manpower needs, how will the public health programs continue to produce the necessary public health manpower with a Federal share of their budgets cut to a level that is 22 percent of the FY 84 level?

Dr. Brandt. The accomplishments of schools of public health in increasing graduates from 1,650 in 1971 to 3,150 in 1981 have largely satisfied needs to increase the total numbers of persons working in public health. A Federal stimulus to increase or even maintain enrollment at higher levels than will naturally occur is, with certain exceptions, no longer necessary. The exceptions include highly-trained individuals specializing in investigation of possible threats to the health of the public and individuals well-qualified to devise appropriate controls for chemicals in the environment. The authority and funds requested will allow us to direct support to these important functions.

The **Chairman**. Well, thank you, Dr. Brandt. I am going to submit most of my questions in writing. I will just ask you a few questions, and if we could have the answers back as soon as you can.

The administration has proposed cutting—and I would also keep the record open for any and all other Senators who have any questions that they would like to ask, in particular Senators Quayle and Grassley have some questions that they will submit in writing. Also, Senator Grassley has a statement that he would like inserted in the record immediately following Senator Kennedy's remarks.

Now, the administration has proposed cutting funding for family medicine and general internal medicine and pediatric training programs. However, several studies have pointed out that these primary care residency programs are unable to generate their own training costs, as long as reimbursement policies favor paying for diagnostic and surgical procedures.

Now, do you think the Federal Government should continue to support those programs?

Dr. **Brandt**. I think the Federal Government should clearly continue to support programs, Mr. Chairman. However, I think it is important that the ultimate success of these programs is going to be when they become completely absorbed into the graduate medical education financing system that currently is clearly being worked upon.

At the present time, if you look at the family medicine and primary care training programs that we we are funding, we are providing a relatively small percentage of the total amount of money that those programs are operating under.

Let me ask Dr. Grabam if he could add a little bit to what I have just said.

Dr. **Graham**. I don't have an exact percentage, Mr. Chairman, but what Dr. Brandt is specifying is true, that over the last decade, with the growth in family medicine—and I would say in a similar way, although to a lesser extent, general internal medicine, general pediatrics—the Federal funds that have been provided have been successful in focusing the attention of the medical profession on the need to increase the number of primary care practitioners—and, indeed, in family medicine, an estimate that I had been working from, that we could document for the record, is that the Federal funds have probably been less than one-tenth of the funds that have gone to support family medicine. The preponderant support for family medicine residencies has been in the State activities.

Now, again, we see a similar trend in internal medicine and pediatrics, perhaps to a lesser extent.

So what we are discussing today is certainly a continued Federal presence and a commitment in fiscal year 1985 and the outyears to continue support for the primary care residencies, but with the expectation that the final solution, making sure that we have an appropriately balanced graduate medical education system, must reside with the sorting out of the necessary means of support for all graduate medical education.

Senator **Kennedy**. Mr. Chairman, would you just yield on that?

The **Chairman**. Sure, go ahead.

Senator **Kennedy**. What indication do you have that the States are going to pick this up? Most of the States now are heavily pressed in terms of their financial needs. Many of the States which have very special needs in the areas of primary care are more in the most difficult financial situation.

What kind of indication have you had that they are prepared to move in and be willing to accept the cutbacks that have been represented by the administration?

Dr. **Brandt**. Well, we are not proposing that State governments would be the only source of funding. But, as you know, it was the action of a number of States that stimulated, if you will, in large part, the growth of family medicine educational programs in this country, particularly those that came into being as part of the higher education system.

I think the fundamental issue, as I see it, is not so much to get the State governments to pay for these any more than they pay for any other aspect of graduate education, but to try to get primary care to be a part of the total spectrum of graduate medical education.

As long as it is outside and as long as we don't consider it to be the same as all the others, then the appropriate emphasis is not going to be put on the program. And that is what concerns me more than anything else.

I think we are going to have to examine the funding of graduate medical education, to provide a stable base; and we know that a number of organizations are looking at this issue now. They have to take into account the critical importance of primary care and of education as a part of that, or the whole system will, in my judgment, collapse.

Senator **Kennedy**. Well, I will come back to this question. I hear what you are saying, and I believe that is one reason we must be especially concerned about the reductions in the authorizations. But I will come back to it in my own time.

The **Chairman**. Let me just ask one other question, and then I will turn to Senator Kennedy.

Could you describe for us, Dr. Brandt, for the committee, the problems relating to the nursing student loan proposed regulation changes, and what the Department is really doing to correct these problems?

Dr **Brandt**. Let me ask Dr Graham, who is much closer to that than I.

The **Chairman** All right.

Dr. **Graham**. Mr. Chairman, as you are aware, not only in the area of nursing student loans but in the health professions student loans, there has been a period of controversy over the last 18 months about the proper degree of stewardship on the part of the institutions in monitoring those loans and making sure that the repayments are on a timely basis, not going into default.

The Department has, over the last year, first, with the health professions student loan program, proposed a series of regulations which became final last June, which would have put additional requirements on the schools to make sure that they are maintaining their student loan delinquencies at an acceptable level; in other words, the target performance level was that there would be no greater than a 5-percent delinquency.

The proposed regulations that would apply to nursing student loans are not yet final; we are still receiving and analyzing comments on them.

We have proposed that the nursing student loan performance criteria would be the same—5-percent delinquency.

There is and we are aware of a lot of concern within the nursing community that that level of delinquency is too rigorous for the nursing schools to meet, that nursing students are different from the other health professions students, and that in essence there should be a higher delinquency level tolerated in the nursing schools.

We are still working with individuals within the Department, still working with the nursing community, to try to determine what the appropriate performance level is for nursing and for health professions.

We will, over the next 6 months, with members of Dr. Brandt's staff, members of the Secretary's staff, be trying to address all of the outstanding issues that relate to nursing student loans and health professions student loans, so that hopefully by the early part of the summer, we will have come to a single determination of how we shall continue to administer those programs.

Dr **Brandt**. I think, Senator Hatch, that it is important to point out that the issue of the health professions student loan and nursing student loan programs, which, as you know, has generated a great deal of congressional attention in the past year or so, is one that is moving towards resolution.

It is clearly a significant problem when we have high percentages of delinquency in these programs from people who are graduates of our health professions schools. These delinquencies are especially distressing to me, since I come from the academic world.

I think, however, that in the health professions area what we are seeing is that the schools have in fact exercised diligence and have begun to respond to this clear need and begun to point out to those who are delinquent or in default, that they do have a responsibility to their fellow students who are following them, to get that money back into the system to be used by the institutions. I think we will come to grips with this and come up with a resolution that will permit everyone to meet their responsibilities.

The **Chairman**. I thank you. Senator Kennedy?

Senator **Kennedy**. If I could defer to Senator Pell.

The **Chairman**. Yes, Senator Pell.

Senator **Pell**. Mr. Chairman, I have another commitment, and I would like permission to leave two questions to be answered for the record, one concerning whether the primary care residency training in podiatric medicine could be—the viewpoint of the Administration in this regard; and the other concerning providing funds for modernization of teaching and research facilities.

And maybe you could answer these at length for the record as soon as possible.

I thank the Chairman and ranking minority member.

[The questions referred to follow:]

QUESTIONS SUBMITTED TO DR. BRANDT FOR THE RECORD BY SENATOR PELL

1. There are a number of Federal programs which provide support for post graduate residency training in the health professions. Podiatric medicine is not currently eligible for such residency training support even though there is a documented need for additional residency slots in this medical field. Has the administration considered and would it be amenable to a program which would extend Federal support for primary care residency training in podiatric medicine?

2. From the late 1960's to the mid 1970's, health professional schools were the recipients of Federal support for construction of teaching and research facilities. Major advances in recent years have rendered many of these facilities technologically insufficient. Has the administration considered providing funds for modernization of these teaching and research facilities?

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. Doctor, as you are very much aware, when we really started the very active Federal involvement in education of health care professionals, there was really not the kind of focus and attention in terms of residency programs, in terms of primary care, which the Nation needed. And then we did a series of hearings to try and find out how we could get a greater focus in the areas of primary care, and found out that many young people were initially interested in it, but many of them went into the medical schools—and, because of a variety of reasons such as medical school emphasis on the glamor and attraction of the specialties, indebtedness, they build up, and the greater continuing educational opportunities—that they went into the specialties.

We built in these hearings with legislation to try, first, to get people into primary care, and, second, to get them in underserved areas. We tried to do something about their indebtedness, we tried to beef up the residency programs, and we tried to get health education programs in underserved areas so they wouldn't be disadvantaged from their other classmates who were going into training hospitals.

But it was a very elaborate program, because there was a variety of different things that affected people going into primary care and into underserved areas. We still have these problems today, even though there has been a significant increase in the numbers, and there has been an increase in the number of residencies.

The concern that I have now is that the creative partnership we have built—and it has been a partnership among the States and the communities and a variety of different centers—is in danger of destruction. The request that this administration has made seriously undermines these important programs if we look at the funding levels for residencies, at support for Public Health Service scholarships, at the program of the administration with regard to indebtedness, at their general attitude with regard to nursing and nurse training. I am dismayed that the administration's program really adds up to a dismantling of what I think was a rather involved balance that was developed over the period of the seventies.

And the brighter aspect of this is that this involved balance really worked well, even by your own evaluation, in terms of increasing the numbers of physicians and other health personnel in primary care and helping to meet some of the needs in underserved areas.

But my concern is that if we begin the dismantling, if we accept the administration's funding levels, we are going to be right back to where we were previously, and the impact of this is not going to be felt in the next 2 or 3 years, but it is going to be felt down the road, and the people that are going to suffer as a result of not being able to get primary care physicians are going to be the underserved in our society

Now, I would just be interested in your own comment about the interrelationship—I've got specific questions, and I will submit them—but your own kind of sense about the interrelationship between a lot of these programs, whether it's the primary care residencies, whether it's the funding program, whether it's the AHEC, or either it's support for public health schools.

How do you think we are going to be able to meet these needs if we dismantle what has been a successful and complex partnership effort. This might save a few millions of dollars, but it could have an enormous impact and will have enormous impact on the quality of health of people in our society.

If you would give us some general reaction to that.

Dr. **Brandt**. As you know, Senator Kennedy, I lived through that whole period, and I think that there is no question that the partnership that you have described has been enormously successful. Certainly the excitement of the late fifties and the early sixties, the scientific progress that was under way, led to the development of an increasing number of subspecialties to deal with those kinds of problems And having gone to medical school during that period of time, I was one of those people—I went to medical school in order to practice in Marietta, OK, which is not quite Washington, DC.

But I, like others, I think, got influenced, caught up in that kind of excitement, and I think that it was necessary to begin to reevaluate that whole effort, and certainly the programs that emerged were very good at that, and, in fact, led to the establishment and the re-awakening of the importance of primary care, and the importance of having good solid academically sound, scientifically based educational programs in these areas.

We have come an awful long way. I am not here to tell you that the problem is solved, because it clearly is not solved in the sense of having what I believe that most people would agree to be an adequate number.

On the other hand, I think that the issue has to do, if you will, with maturity of these kinds of programs. And I think that family medicine, general internal medicine, general pediatrics are now well enough established in the academic and educational community, and recognized as necessary, that it becomes important at some point in time to bring them into the total educational milieu or the total activity of the funding of graduate medical education.

And our judgment is that this is the right time to begin to do that.

I recognize that everybody is not in agreement with this approach, and I fully understand their positions. But the goal behind the approach is to say that this is a problem that cannot any longer be ignored. When you begin to make plans for developing a total graduate medical education program within your institution or to solve a State's problem, you must give ample attention and direction to primary care.

Otherwise we are still caught in the same kind of spiral that we have been caught in.

Senator **Kennedy**. Well, I hear what you are saying, and I respect your own personal commitment. I am troubled by the administration's commitment, however. If you get the reductions in funding you are seeking in terms of scholarship assistance, in terms of support for AHECS, in terms of primary care assistance, it just seems to me that we are in danger of dismantling this commitment that we have in the primary care function, which has been developed over the period of the past, in which nursing and nurse training is an extremely essential and important aspect of it. This is really unlike many other different programs or functions which we have in the Armed Services Committee where you have just a particular weapons system, and you decide yes or no on that system.

This is an interrelationship which has worked and it took a good deal of time in developing, and the kinds of things you are proposing could simply destroy the whole effort.

And this is something that I find enormously troublesome.

I have specific questions in each of these areas, Mr. Chairman. I know you want to move the hearing along. I would be interested in what your current figures are in terms of women in the medical schools, minorities in medical schools, and finally more of people in medical schools.

Do you have those figures now, and can you provide some profile of those that are going to the medical schools, how that has altered or changed.

Dr. **Brandt**. I think we can obtain reasonably accurate figures as to income—I don't happen to have them right in terms of practitioners now in the field—for example, comparing 1970 with 1983—women physicians have gone from about 23,000 or about 8.3 percent of the total in 1970 to around 64,000, or 12.9 percent of the total practicing population in 1983.

Information on black practitioners we don't have at the present time, but we can certainly supply that to you.

In 1970, there were about 6,000 black practicing physicians, or about 2.1 percent of the total number of practitioners. By 1980, the number of black practitioners had increased to about 11,700, or 3.3 percent of the total.

Women enrollment in medical schools has risen from 9.6 percent of the total in 1970-71 to 30.6 percent, or a tripling in 1983-84.

On the other hand, black medical school enrollment has risen only from 3.7 percent in 1970-71 to 5.8 percent in 1983-84.

Senator **Kennedy**. These are just the figures to 1980, is that correct?

Dr. **Brandt**. The enrollment figures are for the current year, 1983-84, and we would be happy to——

Senator **Kennedy**. Would you submit those, because I think our figures are only up till 1980.

Dr. **Brandt**. Yes, sir, we will provide you with the information.

[Information supplied follows:]

MEDICAL SCHOOL ENROLLMENTS

	1970-71		1983-84	
	Number	Percent of total	Number	Percent of total
Total	40,487		67,327	
Minority	2,294	5.7	10,798	16.0
Black	(1,509)	(3.7)	(3,892)	(5.8)
Women	3,894	9.6	20,635	30.6

Senator **Kennedy**. Well, I might have some followup questions in those, because our figures, I think, only go to the 1980 period.

Well, I want to thank you. We will look forward to working with you, and we know of your own personal and Dr. Graham's personal commitment on these areas. As I say, I am just very troubled by the attempt to reduce funding in these areas, and I think if we accept those we will see a significant dismantling of programs which are working and functioning and are interrelated in a very important way to provide primary care, which is essential in terms of health care in our society.

I am going to also have some detailed questions with regard to nurse training and the advanced nurse training program and the reductions in this program, as well as the traineeships and fellowships which would be, as I understand, completely eliminated, am I right? Nurse traineeships and nurse fellowships would be eliminated?

Dr. **Graham**. That is essentially correct. Yes, that is correct, sir.

Senator **Kennedy**. Well, I find that extremely difficult to justify, and I would like to come back to you with some rather specific questions in that program.

Mr. Chairman, if that is agreeable, if I could have some follow-on questions—and some of them will be based upon material that is provided by the administration.

The **Chairman**. That will be fine, and we will keep the record open and permit all Senators on the committee to submit written questions.

Dr **Brandt**. Yes, we will be happy to respond. I think, Mr. Chairman, Senator Kennedy, that from the discussion here I think there is no particular disagreement over our objectives and priorities.

The **Chairman**. I think we are in agreement on that. Thank you. We appreciate both of you coming once again, appreciate having you before the committee.

So we will excuse both of you and turn to our second panel.

Our second panel will discuss title VIII of the Public Health Service Act, the Nurse Training Act.

The first witness will be Dr. Rheba de Tornyay, dean of nursing at the University of Washington, at Seattle. She will speak for the Tri-Council on Nursing, which represents the American Nurses Association, the American Association of Colleges of Nursing, and the National League for Nursing.

And I would like to thank these groups for their efforts in preparation for this hearing.

Accompanying Dr. De Tornyay is Dr. Elaine Larson, a Robert Wood Johnson Clinical Nurse Scholar at the University of Pennsylvania.

From my own home State I am pleased to welcome Dr. Ann Voda from the University of Utah. Dr. Voda is the director of physiological nursing at the College of Nursing in Salt Lake City, and we welcome Dr. Voda and the other witnesses here today.

We are going to accept all written statements into the record, as though fully delivered, and we would appreciate it if you could keep your statements down to about 5 minutes each so we could have some time for questions.

Dr. De Tornyay?

STATEMENTS OF RHEBA DE TORNYAY, R.N., ED.D., DEAN OF THE SCHOOL OF NURSING, UNIVERSITY OF WASHINGTON, SEATTLE, WA, REPRESENTING THE TRI-COUNCIL ON NURSING, ACCOMPANIED BY ELAINE LARSON, R.N., PH.D., F.A.A.N., A ROBERT WOOD JOHNSON CLINICAL NURSE SCHOLAR, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA; AND ANN VODA, R.N., PH.D., UNIVERSITY OF UTAH SCHOOL OF NURSING, SALT LAKE CITY, UT

Dr. DE TORNYAY. Thank you very much, Mr. Chairman. We appreciate this opportunity to present nursing's views on Federal support for nursing education and research.

As you know, in February 1984, the Institute of Medicine of the National Academy of Sciences completed a 2-year study on nursing, including the question of whether Federal aid should be continued for nursing education and research. We applaud the report's conclusion that registered nurses with graduate education are a scarce national resource, and that continued Federal funding to help increase the supply of nurses with graduate education to fill positions in nursing education, nursing administration, nursing research, and as clinical specialists, is warranted.

This recognition of the need for continuing Federal support made by an objective group of representatives from a variety of health-related disciplines is significant.

The current and the past several administrations have attempted to drastically reduce the level of Federal funding for nursing education and research. We are pleased that the Congress has continued to fund these programs at a level in excess of the administration's request, and has understood the value of the Federal Government's role in nursing.

Mr. Chairman, it is obvious that Federal involvement in nursing education and research has been a major success, and needs to be continued. Therefore, we endorse the continuation of the following programs currently included in title VIII:

First, advanced nurse training, which provides institutional support to operate and expand programs for the advanced education of nurses to be teachers, administrators, supervisors, or specialists in parent-child nursing, gerontology, acute care, community health, and medical-surgical nursing.

Second, professional traineeships, including the nurse anesthetist traineeship programs, which provide support to registered nurses at the graduate level, so that they are able to receive advance training.

Third, nurse practitioner training, which provides assistance to institutions to develop and operate programs which train nurse practitioners in primary health care.

And, fourth, special projects which support programs for continuing education, for increasing educational opportunities for individuals from disadvantaged backgrounds, and for developing methods to meet the needs of high-risk groups, such as the elderly, children, and pregnant women.

These programs have been of great benefit to the Nation's effort to improve access to and quality of health care. We believe they should be continued with reasonable increases in their authorization levels.

In addition to maintaining these existing programs, we have proposed the creation of two new programs within title VIII:

First, a demonstration project authority which would provide grants to schools of nursing and other entities for projects to establish nursing education/practice collaborations, to improve access to nursing services in the community, and to improve geographic and specialty distribution of nursing manpower.

Second, a fellowship authority which would provide a specific nursing fellowship program for full-time doctoral students. The number of part-time doctoral students has increased markedly because of the paucity of funding for full-time study.

The addition of these programs to the current law will help toward developing and promoting cost-effective nursing care. It will also greatly enhance our ability to produce the qualified nursing leaders needed.

In our view, title VIII should be funded at approximately the same level suggested in the IOM study, which would be an appropriation of approximately $80 million. Without such a reasonable funding level, the nation will be unable to expand the number of nurses with the skills needed for the growing complexity of care in many health-care settings. In addition, we strongly support raising the level of the existing division of nursing to a Bureau of Nursing within HRSA, and recommend that funds be authorized for start-up costs for such an entity.

Mr. Chairman, the Institute of Medicine study also expressed strong reservations about the underfunding of nursing research. While a substantial share of the health-care dollar is expended on nursing care, there is a remarkable dearth of research in nursing practice The IOM report found the Federal Government's research initiative for nursing to be inadequate. NIH's research budget for fiscal year 1983 exceeded $4 billion, while less than $6 million of Federal funds went to nursing. This represents less than ½ of 1 percent of the Federal dollars for research.

In reviewing the recommendations of the IOM for building a strong research base for nursing, we conclude that the best place for a viable nursing research program would be an Institute of Nursing within NIH. Such an entity would be a focal point for promoting the growth of quality nursing research, and would provide an expanded pool of experienced nurse researchers needed to develop further the knowlege base for nursing practice.

But it is not only nursing research that has been neglected. The health research enterprise of the Federal Government is almost exclusively directed toward basic biomedicine, clinical medicine, and pharmacological research. The behavioral sciences' nursing science, health promotion and rehabilitation medicine have been largely passed over.

For example, the Federal research enterprise must be more in touch with developments and human needs in the field of long-term care. Without a more balanced research agenda on the part of the national governmental agencies and universities, the results will be tragic for our citizens by the end of this decade. A more substantial research base is required to develop regimens and systems that can result in quality cost-effective care for the Nation's aged and chronically ill.

We are pleased that the House of Representatives passed an amendment, H.R. 2350, creating a National Institute of Nursing.

We are also pleased that the Director of NIH, Dr. James Wyngaarden, has recently stated that he will establish a special task force regarding nursing research at NIH. Although this is a positive step. We believe that legislation is still necessary, and we request that the committee consider supporting the concept of a Nursing Institute at NIH.

We very much appreciate the opportunity to present our views. Thank you.

[The prepared statement of Dr. de Tornyay follows:]

PREPARED STATEMENT OF DR. RHEBA DE TORNYAY

Mr. Chairman, I am Dr. Rheba de Tornyay, Dean of the University of Washington-Seattle, School of Nursing. I am appearing today on behalf of the American Association of Colleges of Nursing, the American Nurses'Association, and the National League for Nursing. I appreciate this opportunity to present nursing's views on federal support for nursing education and research.

In February 1984, the Institute of Medicine of the National Academy of Sciences completed a two-year study on nursing, including the question of whether federal aid should be continued for nursing education and research. We applaud the report's conclusion that registered nurses with graduate education are a scarce national resource, and that continued federal funding of nursing education, particularly to help increase the supply of nurses with graduate education to fill positions in nursing education, nursing administration, nursing research, and the clinical specialists, is warranted.

With attempts by this and the past several administrations to dramatically reduce the level of federal funding for nursing education and research, the recognition of the need for continuing federal support by an objective group of representatives from a variety of health related disciplines is significant. We are pleased that the Congress has continued to fund these programs at a level in excess of the Administration's request, and has understood the value of the federal government's role in nursing.

Mr. Chairman, it is obvious that federal involvement in nursing education and research has been an overwhelming success, and needs to be continued. Therefore, we endorse the continuation of the following programs currently included in Title VIII:

1. Advanced nurse training, which provides institutional support to operate and expand programs for the advanced education of

nurses to be teachers, administrators, supervisors, or specialists in parent-child health, gerontology, acute care, community health, and medical-surgical nursing;

2. Professional traineeships, including the nurse anesthetist traineeships program, which provides support to registered nurses at the graduate level, so that they are able to receive advanced training;
3. Nurse practitioner training, which provides assistance to institutions to develop and operate programs which train nurse practitioners in primary health care; and
4. Special projects, which supports programs for continuing education, for increasing educational opportunities for individuals from disadvantaged backgrounds, and for developing methods to meet the needs of high risk groups such as the elderly, children, and pregnant women.

These programs have been of great benefit to the nation's effort to improve access to and the quality of health care. We believe they should be continued with reasonable increases in their authorization levels.

In addition to maintaining these existing programs, we have proposed the creation of two new programs within Title VIII. First, a demonstration project authority, which would provide grants to schools of nursing and other entities for projects to establish nursing education/practice collaborations, to improve access to nursing services in the community, and to improve geographic and specialty distribution of nursing manpower. Second, a fellowship authority, which would provide a specific nursing fellowship program for full-time doctoral students, since the number of part-time doctoral students has increased markedly because of the paucity of funding for full-time study. An addition of these programs to the current law would greatly enhance our ability to produce qualified nursing leaders, and would gain valuable data regarding the increased use of cost-effective nursing care.

In our view, Title VIII should be funded at approximately the same level suggested in the IOM study, which would be an appropriation of approximately $80 million. Without such a reasonable funding level, the nation will be unable to expand the number of nurses with skills commensurate with the growing complexity of care in many health settings. In addition, we strongly support raising the level of the existing Division of Nursing to a Bureau of Nursing within HRSA, and recommend that funds be authorized for start-up costs for such an entity.

Mr. Chairman, the Institute of Medicine study also expressed strong reservations about the underfunding of nursing research. While a substantial share of the health care dollar is expended on nursing care, there is a remarkable dearth of research in nursing practice. The IOM report found the federal government's research initiative for nursing inadequate. NIH's research budget for FY83 exceeded $4 billion, while less than $6 million of federal funds went to nursing. This represent less than one-half of one percent of federal dollars for research.

In reviewing the recommendations of the IOM for building a strong research base for nursing, we conclude that the only place for a viable nursing research program would be an Institute of Nursing within NIH. Such an entity would be a focal point for promoting the growth of quality nursing research, and would provide an expanded pool of experienced nurse researchers needed to further develop the knowledge base for nursing practice.

It is not only nursing research that has been neglected. The health research enterprise of the federal government is almost exclusively directed toward basic biomedicine, clinical medicine, and pharmacological research. Entire fields have been purshed aside by NIH and the University Biomedic Science establishment. Largely passed over has been the behavioral science, nursing science, health promotion and rehabilitation medicine.

For example, the federal research enterprise is out of touch with developments and needs in the field of long-term care. Without a more balanced research agenda on the part of national governmental agencies and universities, the results could be tragic by the end of this decade. A more substantial research base is required to develop regimes and systems that can result in quality, cost effective care for the nation's aged and chronically ill. Helping the nation redirect its goals and dollar allocations for health research is surely a legitimate responsbility of this committee.

We are pleased that the House of Representatives passed an amendment to H.R. 2350 creating a National Institute of Nursing. We are also pleased that Dr. James Wyngaarden, Director of NIH, has recently stated that he will establish a special task force regarding nursing research at NIH. While this is a positive step, we believe that legislation may still be necessary, and request that the Committee seriously consider supporting the concept of a Nursing Institute at NIH.

We appreciate this opportunity to present our views on nursing education and research. THANK YOU!

The CHAIRMAN. Thank you, Dr. de Tornyay.

Senator KENNEDY. Mr. Chairman, I am going to have to leave. I just have one question.

The CHAIRMAN. Why don't you go ahead?

Senator KENNEDY. The administration quotes the study on certain conclusions, but effectively ignores some of the most important conclusions of the study of other areas particularly in terms of funding for the continuing of the farming program.

I notice you have referenced that, but I just want to point out to the committee that this study that was done by the Institute made some very specific recommendations with regards to a variety of different nurse training programs, and outlines what is absolutely essential if we are going to continue to have an effective nurse training function.

The administration funding request—perhaps the other witnesses will refer to it—would effectively destroy existing programs and ignore some very important new programs.

I would just be interested in your reaction to this, and maybe other witnesses will comment on it.

I will submit some other questions, but I would be interested in your reaction.

Dr. DE TORNYAY. Yes, your question is what specific areas were left out?

Senator KENNEDY. Well, the administration cites the study as saying, basically, look, we have got enough for nurses, we have got enough training programs, and then the administration comes back in and says, therefore we are going to see a dramatic reduction from a $54 million to a $14 million request, while the institute study, for example, asked for 80, if we are going to continue criminal training efforts.

That is something that was kind of left out in the earlier discussion.

And I just would like, if you would, for you to respond to that.

Dr. DE TORNYAY. Yes, well, I think if that were to occur it's going to cut programs and bring back a critical nursing shortage, particularly in the leadership area. I think the IOM study pointed out the factor that there probably is less of a shortage in the generalist area, but in terms of clinical specialists, it is absolutely critical that that continue, and certainly in the area of doctoral fellowships.

Senator KENNEDY. I will have some specific questions in those areas, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kennedy. Dr. Voda, we will turn to you now.

Dr. VODA. I, too, appreciate the opportunity to present my view of Federal support for nursing, and, in addition to the introduction that Senator Hatch gave, I am a nurse scientist. I will focus my comments on two areas: One, my experience as a scientist; and, two, my opinion of important research that is not being funded.

I earned a bachelor's degree in nursing at the University of California, Los Angeles, passed the State board examination for licensure, practiced and taught nursing and earned a Ph.D. in animal physiology at the University of Arizona at Tucson My research training was in reproductive and metabolic endocrinology.

I have been working to establish a research program consistent with my training. My specialty areas are metabolic consequences of illness and women's reproductive health.

I am one of a few nurses in the country who have been awarded a National Institute of Health research grant.

In 1978 a National Institute of Aging grant was awarded for 1 year to study menopause. I reapplied to NIA for money to continue work on menopause to test hypotheses generated from the first grant. A 3-year application was approved by NIA's Scientific Review Committee and ranked at 2.53. The cutoff point for funding was above my rating, less than 2, and on the advice of an NIA program officer I transferred the approved grant to the Division of Nursing.

In September 1980 the grant was funded from the Division of Nursing for the 3-year period.

In the spring of 1982 I received a letter from Jo Eleanor Elliott, Director, Division of Nursing, Health Resources Administration, Bureau of Health Professions, advising me that the appropriation for fiscal year 1982 for research grants was $2.4 million compared with $5 million for the previous year and that my grant would be funded at approximately 55 percent of the amount previously recommended. I was asked to describe how reduced funding would alter my research plans. This took time away from my research and I wondered whether I would be able to complete the project.

The entire process was frustrating and demoralizing. I questioned the value assigned to nursing research or at least research funded out of HRA since I knew that NIH had received no budget cuts.

I did complete the research. Some data collection and analysis had to be abandoned. Subsequently the budget was reinstated to 85 percent of the original award, but the uncertainty of knowing how much money I would have was most undesirable and a nonproductive use of tax dollars.

Despite the cuts imposed, Mr. Chairman, the citizens have benefitted from my research. As a scientist, I am indebted to the citizens who provide tax dollars to fund research. As a result I have shared the research findings with both the scientific community and the citizens who are consumers of research. A publication, "Menopause, Me and You," is widely used by consumers and care providers in health promotion.

In my role as teacher and mentor I am able to maximize my physiology and nursing education by developing and teaching courses that help students comprehend the biological and behavioral correlates of illness and to pose research questions consistent with their experience and training. I teach students how to apply up-to-date biomedical and psychosocial research findings in the practice situation. They learn that no matter what the cause of illness, treatment is now directed at the cell molecular level. Nurses are astute consumers of research. On the one hand, they are expected to use this knowledge in the practice setting as they work with physicians to carry out a medical treatment plan, one designed to evoke a healing response in a person with disease, like cancer. On the other hand, once delegated tasks are done, the nurse is not expected to use knowledge to help patients cope with the human responses, to illness and/or the treatment. These human responses, at least in the acute care setting, are the concern and domain of nursing.

Some examples are: nausea, vomiting and diarrhea associated with cancer chemotherapy; pain, fear, anger, anxiety associated with surgery; or the fatigue, restlessness, confusion, sleep deprivation, incontinence and body alterations associated with mutilating or transplant surgery.

To put it simply, Mr. Chairman, research on the human responses to illness have been pushed aside because of the overpowering emphasis and quest for knowledge via biomedical research.

At the University of Utah we have a critical mass of nurse scientist/teachers who have been trained in rigorous scientific disciplines. We understand research. we also know that there are many research questions important to human and humane patient care that are not being addressed. Time allows only one example.

In conference with a graduate student last week, the student said:

> I am very interested in sleep patterns of intensive care patients. I believe I am the patient's advocate and should have a strong voice in saying "This patient has only rested for 15 minutes since return from nuclear medicine, do not disturb, he needs his sleep." I say this because I or another nurse is at the bedside 24 hours, 7 days a week I need to make sure that night time is a time to sleep and that multiple procedures are not being done without allowing rest periods. Yet the concepts of "sleep" and "rest" are thrown out the window once a patient is admitted to ICU. It's time we defend the patient's right to sleep. Yet I have little research to draw upon and when I raise questions I am not taken seriously.

Mr. Chairman, I take these questions very seriously, and I hope that your committee will give consideration to providing a mechanism for a stable funding base for nursing and that moneys be appropriated for nursing similar to amounts provided for the National Institutes of Health. I also hope that you will consider an institute structure for nursing, where hands-on basic research into human responses can be carried out

I believe that an institute structure would provide opportunities for multidisciplinary-prepared nurse scientists to work collaboratively with scientists from other disciplines. Collaboration and use of pluralistic methods of research will address questions related to human responses and, more importantly, I believe will develop a body of knowledge which will promote quality, humane, and cost-effective care.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Voda and response to Senator Grassley's questions follows:]

TESTIMONY TO

THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE

SENATOR ORRIN HATCH, CHAIRMAN

MARCH 14, 1984

ANN M. VODA, PH.D., PROFESSOR
DIRECTOR OF PHYSIOLOGICAL NURSING
UNIVERSITY OF UTAH
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MR. CHAIRMAN, I AM DR. ANN VODA, PROFESSOR AND DIRECTOR OF PHYSIOLOGICAL NURSING, UNIVERSITY OF UTAH COLLEGE OF NURSING. I AM A NURSE SCIENTIST. I APPRECIATE THE OPPORTUNITY TO PRESENT MY VIEW OF FEDERAL SUPPORT FOR NURSING. I WILL FOCUS MY COMMENTS ON TWO AREAS: ONE MY EXPERIENCE AS A SCIENTIST, AND TWO, MY OPINION OF IMPORTANT RESEARCH THAT IS NOT BEING FUNDED.

I EARNED A BACHELOR"S DEGREE IN NURSING AT THE UNIVERSITY OF CALIFORNIA, LOS ANGELES, PASSED THE STATE BOARD EXAMINATION FOR LICENSURE, PRACTICED AND TAUGHT NURSING AND EARNED A PH.D. IN ANIMAL PHYSIOLOGY AT THE UNIVERSITY OF ARIZONA AT TUCSON. MY RESEARCH TRAINING WAS IN REPRODUCTIVE AND METABOLIC ENDOCRINOLOGY. I HAVE BEEN WORKING TO ESTABLISH A RESEARCH PROGRAM CONSISTANT WITH MY TRAINING. MY SPECIALTY AREAS ARE METABOLIC CONSEQUENCE OF ILLNESS AND WOMEN'S REPRODUCTIVE HEALTH. I AM ONE OF A FEW NURSES IN THE COUNTRY WHO HAVE BEEN AWARDED AN NATIONAL INSTITUTE OF HEALTH RESEARCH GRANT. IN 1978 AN NATIONAL INSTITUTE OF AGING (NIA) GRANT WAS AWARDED FOR ONE YEAR TO STUDY MENOPAUSE. I REAPPLIED TO NIA FOR MONEY TO CONTINUE WORK ON MENOPAUSE TO TEST HYPOTHESES GENERATED FROM THE FIRST GRANT. A 3-YEAR GRANT APPLICATION WAS APPROVED BY NIA'S SCIENTIFIC REVIEW COMMITTEE AND RANKED AT 2.53. THE CUT-OFF POINT FOR FUNDING WAS ABOVE MY RATING, LESS THAN 2, AND ON THE ADVICE

OF AN NIA PROGRAM OFFICER I TRANSFERRED THE APPROVED GRANT TO THE DIVISION OF NURSING. IN SEPTEMBER 1980 THE GRANT WAS FUNDED FROM THE DIVISION FOR THE 3-YEAR PERIOD. IN SPRING OF 1982 I RECEIVED A LETTER FROM JO ELEANOR ELLIOTT, DIRECTOR, DIVISION OF NURSING, HEALTH RESOURCES ADMINISTRATION, BUREAU OF HEALTH PROFESSIONS, ADVISING ME THAT THE APPROPRIATION FOR FISCAL YEAR 1982 FOR RESEARCH GRANTS WAS $2.4 MILLION COMPARED WITH $5 MILLION FOR THE PREVIOUS YEAR AND THAT MY GRANT WOULD BE FUNDED AT APPROXIMATELY 55% OF THE AMOUNT PREVIOUSLY RECOMMENDED. I WAS ASKED TO DESCRIBE HOW REDUCED FUNDING WOULD ALTER MY RESEARCH PLANS. THIS TOOK TIME AWAY FROM MY RESEARCH AND I WONDERED WHETHER I WOULD BE ABLE TO COMPLETE THE PROJECT. THE ENTIRE PROCESS WAS FRUSTRATING AND DEMORALIZING: I QUESTIONED THE VALUE ASSIGNED TO NURSING RESEARCH OR AT LEAST RESEARCH FUNDED OUT OF HRA SINCE I KNEW THAT NIH HAD RECEIVED NO BUDGET CUTS. I DID COMPLETE THE RESEARCH. SOME DATA COLLECTION AND ANALYSIS HAD TO BE ABANDONED. SUBSEQUENTLY THE BUDGET WAS REINSTATED TO 85% OF THE ORIGINAL AWARD BUT THE UNCERTAINTY OF KNOWING HOW MUCH MONEY I WOULD HAVE WAS MOST UNDESIRABLE AND A NONPRODUCTIVE USE OF TAX DOLLARS. DESPITE THE CUTS IMPOSED, MR. CHAIRMAN, THE CITIZENS HAVE BENEFITTED FROM MY RESEARCH. AS A SCIENTIST I AM INDEBTED TO THE CITIZENS WHO PROVIDE

TAX DOLLARS TO FUND RESEARCH. AS A RESULT I HAVE SHARED THE RESEARCH FINDINGS WITH BOTH THE SCIENTIFIC COMMUNITY AND THE CITIZENS WHO ARE CONSUMERS OF RESEARCH. A PUBLICATION, MENOPAUSE, ME AND YOU, IS WIDELY USED BY CONSUMERS AND CARE PROVIDERS IN HEALTH PROMOTION.

IN MY ROLE AS TEACHER AND MENTOR I AM ABLE TO MAXIMIZE MY PHYSIOLOGY AND NURSING EDUCATION BY DEVELOPING AND TEACHING COURSES THAT HELP STUDENTS COMPREHEND THE BIOLOGICAL AND BEHAVIORAL CORRELATES OF ILLNESS AND TO POSE RESEARCH QUESTIONS CONSISTENT WITH THEIR EXPERIENCE AND TRAINING. I TEACH STUDENTS HOW TO APPLY UP-TO-DATE BIOMEDICAL AND PSYCHOSOCIAL RESEARCH FINDINGS IN THE PRACTICE SITUATION. THEY LEARN THAT NO MATTER WHAT THE CAUSE OF ILLNESS, TREATMENT IS NOW DIRECTED AT THE CELL MOLECULAR LEVEL. NURSES ARE ASTUTE CONSUMERS OF RESEARCH. ON THE ONE HAND THEY ARE EXPECTED TO USE THIS KNOWLEDGE IN THE PRACTICE SETTING AS THEY WORK WITH PHYSICIANS TO CARRY OUT A MEDICAL TREATMENT PLAN, ONE DESIGNED TO EVOKE A HEALING RESPONSE IN A PERSON WITH DISEASE, LIKE CANCER. ON THE OTHER HAND, ONCE DELEGATED TASKS ARE DONE, THE NURSE IS NOT EXPECTED TO USE KNOWLEDGE TO HELP PATIENTS COPE WITH THE HUMAN RESPONSES TO ILLNESS AND/OR THE TREATMENT. THESE HUMAN RESPONSES, AT LEAST IN THE ACUTE CARE SETTING, ARE THE CONCERN AND DOMAIN

OF NURSING. SOME EXAMPLES ARE: NAUSEA, VOMITTING AND DIARRHEA ASSOCIATED WITH CANCER CHEMOTHERAPY; PAIN, FEAR, ANGER, ANXIETY ASSOCIATED WITH SURGERY: OR THE FATIGUE, RESTLESSNESS, CONFUSION, SLEEP DEPRIVATION, INCONTINENCE AND BODY ALTERATIONS ASSOCIATED WITH MUTILATING OR TRANSPLANT SURGERY. TO PUT IT SIMPLY, MR. CHAIRMAN, RESEARCH ON THE HUMAN RESPONSES TO ILLNESS HAVE BEEN PUSHED ASIDE BECAUSE OF THE OVERPOWERING EMPHASIS AND QUEST FOR KNOWLEDGE VIA BIOMEDICAL RESEARCH.

AT THE UNIVERSITY OF UTAH WE HAVE A CRITICAL MASS OF NURSE SCIENTIST/TEACHERS WHO HAVE BEEN TRAINED IN RIGOROUS SCIENTIFIC DISCIPLINES. WE UNDERSTAND RESEARCH: WE ALSO KNOW THAT THERE ARE MANY RESEARCH QUESTIONS IMPORTANT TO HUMAN AND HUMANE PATIENT CARE THAT ARE NOT BEING ADDRESSED. TIME ALLOWS ONLY ONE EXAMPLE. IN CONFERENCE WITH A GRADUATE STUDENT LAST WEEK, THE STUDENT SAID:

> "I AM VERY INTERESTED IN SLEEP PATTERNS OF INTENSIVE CARE PATIENTS. I BELIEVE I AM THE PATIENT'S ADVOCATE AND SHOULD HAVE A STRONG VOICE IN SAYING 'THIS PATIENT HAS ONLY RESTED FOR 15 MINUTES SINCE RETURN FROM NUCLEAR MEDICINE.... DO NOT DISTURB....HE NEEDS HIS SLEEP.' I SAY THIS BECAUSE I OR ANOTHER

NURSE IS AT THE BEDSIDE 24 HOURS, 7 DAYS A WEEK. I NEED TO MAKE SURE THAT NIGHT TIME IS A TIME TO SLEEP AND THAT MULTIPLE PROCEDURES ARE NOT BEING DONE WITHOUT ALLOWING REST PERIODS. YET THE CONCEPTS OF 'SLEEP' AND 'REST' ARE THROWN OUT THE WINDOW ONCE A PATIENT IS ADMITTED TO ICU. IT'S TIME WE DEFEND THE PATIENT'S RIGHT TO SLEEP: YET I HAVE LITTLE RESEARCH TO DRAW UPON AND WHEN I RAISE QUESTIONS I AM NOT TAKEN SERIOUSLY."

MR. CHAIRMAN, I HOPE THAT YOUR COMMITTEE WILL GIVE CONSIDERATION TO PROVIDING A MECHANISM FOR A STABLE FUNDING BASE FOR NURSING AND THAT MONIES BE APPROPRIATED FOR NURSING SIMILAR TO AMOUNTS PROVIDED FOR THE NATIONAL INSTITUTES OF HEALTH. I ALSO HOPE THAT YOU WILL CONSIDER AN INSTITUTE STRUCTURE FOR NURSING, WHERE HANDS ON BASIC RESEARCH INTO HUMAN RESPONSES CAN BE CARRIED OUT. I BELIEVE THAT AN INSTITUTE STRUCTURE WOULD PROVIDE OPPORTUNITIES FOR MULTIDISCIPLINARY-PREPARED NURSE SCIENTISTS TO WORK COLLABORATIVELY WITH SCIENTISTS FROM OTHER DISCIPLINES. COLLABORATION AND USE OF PLURASTIC METHODS OF RESEARCH WILL ADDRESS QUESTIONS RELATED TO HUMAN RESPONSES AND MORE IMPORTANTLY I BELIEVE WILL DEVELOP A BODY OF KNOWLEDGE WHICH WILL PROMOTE QUALITY, HUMANE AND COST-EFFECTIVE CARE.

RESPONSE TO SENATOR CHARLES E. GRASSLEY'S QUESTION, 3/14/84

YOU HAVE IDENTIFIED A NUMBER OF NEEDS IN NURSING EDUCATION. ARE YOU IN A POSITION TO IDENTIFY WHAT THE HIGHEST PRIORITIES SHOULD BE FOR SUPPORT OF NURSING EDUCATION?

I believe that Dr. Detornay has addressed the answer to the question in her testimony. Consistent with my testimony, I am convinced that with an increase in support for graduate education in nursing - to support the training of researchers, administrators, and educators - we will be able to provide answers to the question "how cost-effective is nursing?"

Ann M. Voda, Ph.D.
Professor/Director
Physiological Nursing

AMV:sg

The **Chairman**. Thank you, Dr. Voda. Let me just ask you this question, as a nurse educator and researcher: What do you recommend as the most effective way for the Federal Government to encourage nursing research?

Dr. **Voda**. To encourage nursing research?

The **Chairman**. Yes. Or to encourage nurses to get into research.

Dr. **Voda**. To go into research.

The **Chairman**. Sure.

Dr. **Voda**. Well, I believe one of the most effective ways is to have more people like myself—and we do have a critical mass of nurse researchers now in the country. I believe 4,000 is the figure. And I believe in my role as teacher and mentor for graduate students at the University of Utah where I work, and at the University of Arizona, another school with a fine doctoral program where I have—as I work with graduate students—this example I have provided for you is but one of many that I could provide you with. These students are asking the critical questions, the students have very fine minds; but we have no place to go, because there are obstructions to our trying to research what we think are the nursing research problems.

So the first thing I think we need to do is to think about ways that we can remove some of these obstructions to research. And I am not saying that money is the primary one, but if we think about the obstructions, money is certainly one of the most important.

I think we have the role models and we have the critical mass of nurse researchers and we have the students who are wanting to go on and learn how to be scientists.

The **Chairman**. Well, our bill will contain a Center for Nursing Research, which we hope we can fund at a reasonable starting level. And that may be helpful to you.

You have indicated that cost-effectiveness is also an important issue in today's health care industry. And could you just give us some indication what are some of the specific adaptations of nursing research that really would save consumer health care dollars?

Dr. **Voda**. Well, Mr. Chairman, I believe someone else might be able to answer that with more specific data, but I would like to say that if nursing had the opportunity to do the research on the questions that are being raised by nurses in the clinical area we would have cost-effectiveness data. However, there are obstructions to doing research in many ways so that we are not able to provide that data in the acute care situation.

The **Chairman**. Dr. Larson?

Dr. **Larson**. Mr. Chairman, I would like to give you some examples of research that is cost-effective. As a member of a caring profession—and I hope we continue to be considered a caring profession—I am glad to see you have your teddy bear there, I hope that he's therapeutic——

The **Chairman**. For those of you who don't understand why I carry my teddy bear with me, this is a T-Bear, which is a new symbol being put out, to try and get in children's cases, to have children have these bears to remind their doctors, their nurses, their medical care people, to wash their hands before they handle these children.

Dr. LARSON. That's wonderful.

Dr. VODA. Very good.

The CHAIRMAN. And by having this the child will be able to stand up for his or her rights, and say I hope you have washed your hands before you care for me—and, by the way, this was developed by nurses.

Dr. LARSON. That's wonderful.

The CHAIRMAN. This one has a heart—Ed Brandt said in my case it ought to be over the right breast—but it's got a heart with an "Orrin" on it; I thought it was pretty nice.

Go ahead, I'm sorry to interrupt you.

Dr. LARSON. That's fine, it's actually quite appropriate. My master's is in microbiology, my doctorate is in epidemiology—and actually I have spent the last 7 years doing research on hand-washing, and it's an excellent example of cost-effectiveness. I will give you a few more, but I will just tell you a little bit about what we are doing with hand-washing.

Despite the fact that for over a hundred years we have known that hands of hospital personnel do spread infections, we recently did a study in which we found on the hands of hospital personnel, on one-fourth of hands, people carried the organisms that are causing hospital infections, both hospital personnel and patients.

Despite that fact, we also found that less than half of physicians and nurses, after contacting an infected patient, are washing their hands.

Now, we have worked as nurses on a very different aspect of research, and that is how does one increase compliance with behavior changes, and it's fine to have knowledge about something—but our belief as nurses is that finding new knowledge doesn't end your responsibility as a researcher and as a health care provider.

A hundred years have gone by, hand-washing still does not occur—and why is there this discrepancy?

So we have worked for the past several years on some interventions to change people's behavior regarding hand-washing. And we have been very successful in increasing compliance of physicians and nurses with two specific techniques that we are using, that I don't need to go into. We have many examples in our written testimony about cost-effective research in nursing, and I don't need to talk about all of them, but I will just mention a few.

In addition to our hand-washing research, which I believe can save us millions of dollars a year, we have 2 million nosocomial; that is, hospital-acquired infections per year in this country. Over 80 percent of infection control practitioners in the United States are nurses, and there have been some very nice studies in the past few years that have demonstrated the ability of such practitioners to decrease nosocomial infections. Currently we are spending $6 billion a year on infections that are incurred by patients in the hospital; many of those could be prevented if we can change people's behavior in terms of hand-washing.

Now, if we can change people's behavior, we are in good shape for anything, that's true, regardless of what your profession is.

The CHAIRMAN. But we need to have the knowledge to do it, too.

Dr. LARSON. I think we are making some inroads there.

A couple of other studies I would just like to tell you about. Dr. Claire Fagan, who is the dean at the University of Pennsylvania School of Nursing, has written an excellent article which was published last year, in which she cites several dozen research studies which have proven to save money.

Nurses are saving money in two ways, partly as providers of care. There are many studies that indicate that nurse practitioners and those in primary care—I would like to sort of second what Senator Kennedy said, and that is that primary care is really a place where we can begin to save money, as we prevent lengthy stays in hospitals. Nurse practitioners have been shown to be as competent and, in some cases, more competent for certain types of diseases, in providing primary care.

Preoperative teaching interventions by nurses have been shown to decrease length of hospital stay, to decrease the use of analgesics, that is, pain medication, among patients. Interventions by nurses with premature infants, who have trained babies to suck earlier—babies need to learn to suck if they are born too early—have shown that they can reduce hospital stays by an average of 4 days, and they estimated, in one study, that they would save $52 million a year by reducing the stay for an average of 4 days per baby. This is really astounding, because that study cost $4,000, which was a little bit more than saving 4 days for one baby.

The thing that is so amazing about nursing research is it's cheap. And it seems to me that every time I look at nursing research, we are saving money when we do that research.

Another, I thought very compelling study, was a nursing intervention with mothers who were known to be at high risk for child abuse In a randomly—they randomly divided mothers into an intervention group, and had a control group. Among the control group, 90 percent of the children within 6 months were hospitalized for child abuse, and among the experimental group, which was the nursing intervention—it involved training mothers in how to respond to babies and so forth—none of the babies were hospitalized for anything, for child abuse. And about 90 percent of those babies showed improvement in their health.

Now, the problem is that at NIH only 20 percent of the—a group of studies that were submitted last year, proposals that were submitted for consideration and were of scientific merit, acceptable scientific merit, were within the current priorities of NIH for funding.

Nurses have really emphasized preventive care, and sometimes it is hard to demonstrate that you have prevented an infection by washing your hands or that you have prevented a bed sore.

The CHAIRMAN. We have a rough time making that scintillate in this committee, too. I have been a very strong supporter of preventive health care, and, frankly, you are making a lot of sense here to this committee today.

Dr. LARSON. I think that we have demonstrated very clearly in our hand-washing research, through 11 publications and 1 book so far, and these people who are preventing child abuse—we are becoming more sophisticated in being able to demonstrate that we are preventing problems. And, for example, right now, there is a cyclotron being put in at NIH which costs almost $2 million. Now, the proposed appropriations for the Division of Nursing for all of nursing research next year is $2 million.

And when you think about the increased ability to diagnose problems, which we will get with the cyclotron, and compare that with our ability to improve the quality of life and to deal with preventive aspects of care and to look at chronic illness, I think that there is somewhat of an inequity there.

The **Chairman**. You have convinced me. You have made a very good presentation.

Dr. de Tornyay, let me ask you one question. You stated that the Tri-Council would support creating a Bureau of Nursing within the Health Resources and Services Administration.

Dr. **de Tornyay**. Yes.

The **Chairman**. Would you also support a Center for Nursing Research within that Bureau?

Dr. **de** Tornyay. There would be some concerns, and these are the reasons. We believe that there are two criteria that really need to be followed for an institute for nursing, are that there be high visibility for nursing research, and also that nursing research be placed in the mainstream of research.

And for that reason we believe the NIH would be the appropriate place for such a center or institute.

The **Chairman**. Thank you.

Dr. **Larson**. Senator Hatch, I would like to respond to that, if I might.

The **Chairman**. Yes.

Dr. **Larson**. I just spent the last month looking through the Congressional Records and doing some research in preparation for this on how the previous institutes were started. And I would just like to say that in every case the same objections have been raised by the same groups of people, which one needs to do because it is part of one's job in certain jobs, and it is part of our job, as the special interest group to represent the other side of it—and what I would like to say is that historically it has happened that when an institute has come into being, research has thrived in that area.

And there is just no way to get around that fact.

And when I look at the kinds of research that we are doing in nursing, that I don't see any other group addressing problems—it's not that nurses are the only ones who can do the research; it is that we are the only ones who are doing it. Then I think that it puts things into a perspective.

The **Chairman**. Well, thank you, Dr. Larson. I am going to submit the rest of our questions in writing and keep the record open for other Senators to do the same. And we appreciate the help that you have been to this committee on this legislation.

And thank you so much for being here.

Dr. **de Tornyay**. Thank you very much.

The **Chairman**. We will now turn to our third panel. I am pleased to welcome a distinguished panel of witnesses here to testify regarding the Health Professions Training Assistance Act.

And our first witness will be Dr. David Satcher, who is president of Meharry Medical College, representing the Association of Minority Health Professions Schools and the American Academy of Family Physicians.

He will be followed by Dr. Alan Nelson, a good friend of mine, who is a practicing physician in Salt Lake City, UT, and he is here representing the American Medical Association.

And, finally, I am pleased to welcome Mr. Charles Terrell, who is the assistant dean for student affairs at Boston University School of Medicine.

So we will begin with Dr. Satcher.

Doctor, I have a terrible problem: I have to be on the floor at quarter to 12.

And so what I am going to do is I am going to start this panel. I may have to have Dr. Sundwall on my staff finish up the panel, because it is important that we have all the information into the record that you people have brought with you today.

I just hope you won't be offended that I have to be over there. We are trying to at least resolve some problems that may help you in the medical profession by having school prayer, voluntary school prayer, again.

And, unfortunately, I have got to be there.

So we will start with you and I just hope you won't be offended. Dr. Satcher?

STATEMENTS OF DAVID SATCHER, M.D., PH.D., PRESIDENT OF MEHARRY MEDICAL COLLEGE, NASHVILLE, TN, REPRESENTING THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS AND THE AMERICAN ACADEMY OF FAMILY PHYSICIANS; ALAN R. NELSON, M.D., TRUSTEE OF THE AMERICAN MEDICAL ASSOCIATION, INTERNIST IN PRIVATE PRACTICE, SALT LAKE CITY, UT; AND CHARLES TERRELL, ASSISTANT DEAN FOR STUDENT AFFAIRS OF BOSTON UNIVERSITY SCHOOL OF MEDICINE, BOSTON, MA, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. **Satcher**. Thank you, Chairman Hatch and other members of the committee. It is a pleasure for me to present to this committee on behalf of the Association of Minority Health Professions Schools. I am joined here today by Dr. Walter Bowie, who is dean of the School of Veterinary Medicine at Tuskegee.

It is also a pleasure to speak on behalf of the American Academy of Family Physicians, of which I am a member.

We appreciate this opportunity to present our views regarding reauthorization of the Health Personnel and Manpower Training Act.

The member institutions of the association include the Morehouse School of Medicine, the Tuskegee Institute School of Veterinary Medicine, the Xavier University School of Pharmacy, the Florida A&M University College of Pharmacy, Texas Southern University School of Pharmacy, Charles R. Drew Postgraduate Medical School, and the Meharry Medical and Dental Colleges.

All of these institutions have a vital interest in the programs authorized by this act.

The eight institutions represented by our association have graduated 43 percent of the Nation's black physicians and dentists, 50 percent of the Nation's black pharmacists, and 90 percent of the Nation's black veterinarians.

Many programs contained in this act profoundly affect the educational missions and success of our institutions, and our collective and individual goals to increase the number of black and other minority health professionals in the Nation.

The institutions represented by the association, as well as our students, rely heavily upon this Federal support.

Please allow me, Mr. Chairman, to thank you and your dedicated staff for the interest and commitment you have displayed to us recently regarding minorities in the health professions.

The President's budget proposals for fiscal year 1985 request Congress to eliminate and/or make significant cuts in health professions programs vital to the survival and maintenance of the progress being made by minority institutions and minority students. In fact, the President's budget for health professions for fiscal year 1985 proposes cuts of $85 million from the current fiscal year 1984 program levels.

Of these cuts, several reach deep into the financial base that is necessary for many minority students to continue their education. Funds for health professions student loans, exceptional financial need scholarships, and National Health Service Corps scholarships that many exceptional financial need recipients receive to continue medical education, have been proposed for elimination.

The Association of Minority Health Professions Schools does not believe this adequately reflects, by any means, the administration's current stated commitment to accelerate efforts to strengthen minorities in the health professions.

I would also like to add that the American Academy of Family Physicians looks upon the President's budget proposals for family medicine units and residency programs under this act as being far short of the necessary amounts to continue a reasonable level of support.

On June 16, 1983, at a press conference in the U.S. Capitol, a comprehensive study was announced, which had been funded by the Robert Wood Johnson Foundation, entitled "Blacks in the Health Professions in the 1980's: A National Crisis and a Time for Action."

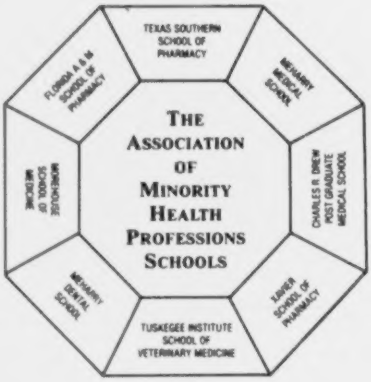
Senator Hatch, we appreciate the fact that you supported the release of this study and getting this information to the public.

This study documents the severe shortage of black physicians, dentists, veterinarians, and pharmacists in the United States. I am pleased to submit a copy of this study to the committee, which contains abundant data to support the conclusions cited.

The CHAIRMAN. Without objection, we will place a copy of that study in the record at this point.

[The following was received for the record:]

BLACKS AND THE HEALTH PROFESSIONS IN THE 80's: A NATIONAL CRISIS AND A TIME FOR ACTION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XAVIER SCHOOL OF PHARMACY
TUSKEGEE INSTITUTE SCHOOL OF VETERINARY MEDICINE
MEHARRY DENTAL SCHOOL
MOREHOUSE SCHOOL OF MEDICINE
FLORIDA A & M SCHOOL OF PHARMACY
THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

JUNE 1983

BLACKS AND THE HEALTH PROFESSIONS IN THE 80's: A NATIONAL CRISIS AND A TIME FOR ACTION

Prepared for the Association of Minority Health Professions Schools

by

Ruth S. Hanft, Linda E. Fishman and Wendy J. Evans

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PREFACE

The founding of the United States more than 200 years ago was based on the principle of equal opportunity under the law for all citizens.

However, for black Americans and other ethnic minorities, this ideal has often been attained only after protracted and intense efforts.

In the health professions in the United States, the ratio of black physicians, dentists, veterinarians and pharmacists to the black population has never been equal to the percentage of these health professionals in the white population.

This is the legacy of decades of segregation and discrimination which, until the late 1960s, resulted in unequal educational opportunity, including a relative lack of access to a health professions education for black Americans.

Thus historically, there has been, and continues to be, a severe shortage of black health professionals in the United States. As a population group, blacks have more illness and a significantly shorter life expectancy than do whites in the United States.

Black health professionals should - and do - provide health care to blacks, whites and other groups, as do white professionals, and this is as it should be in our increasingly integrated society. However, there should be ample numbers of black health professionals so that there can be the opportunity for true freedom of choice of health professional by the consumer of health services. Similarly, in many urban ghettoes and rural areas with a high percentage of black residents, our nation's history has demonstrated that there is a greater likelihood that a health professional establishing a practice in such an area will be black.

As a nation, we need to utilize the most talented individuals available for the demanding health professions in an effort to improve the health status of our citizens and to improve our nation's system of health care. For blacks, who are aware of the fact that, compared with whites, their lives are shorter, their pregnant mothers and their infants die more frequently, and they have a greater burden of illness and disability, the statement that the United States has the best system of medical care in the world has a hollow ring.

Based upon the findings reported in 1980 by the Graduate Medical Education National Advisory Committee (GMENAC), there is an increasing belief that by 1990, the United States may have a surplus of health professionals. However, in its report, GMENAC observed that there was a shortage of black and other minority health professionals, and that "care should be taken to assure that programs designed to increase the number of minority health professionals are not thwarted," during the implementation of recommended reductions in training capacity of medical education programs. As shown in this study, there continue to be severe shortages of black physicians, dentists, pharmacists and veterinarians in the United States, and present trends presage greater shortages of minority health professionals in the United States through the year 2000, and beyond. Along with other factors, these shortages contribute to the appalling health statistics and the shortened life expectancy of the black population in the United States.

A number of issues are raised by these findings and some policy options are proposed for consideration and implementation by public and private agencies concerned with the health of the American population.

We are grateful to the Robert Wood Johnson Foundation for supporting this study with a grant to the Morehouse School of Medicine. The study was carried out with the cooperation and participation of the Association of Minority Health Professions Schools. Members of the Association include the Morehouse School of Medicine, the Meharry Schools of Medicine and Dentistry, the Tuskegee Institute School of Veterinary Medicine, the Florida A and M University College of Pharmacy, the Texas Southern University School of Medicine, the Xavier University of Louisiana School of Pharmacy, and the Charles R. Drew Medical School.

I am grateful to the Presidents and Deans of these institutions and their colleagues for their cooperation and support in the collection and analysis of the data, and their review and criticism of the study.

Finally, I wish to express my gratitude to Ms. Ruth Hanft for her untiring efforts and varied activities in carrying out this very important study, which would serve as a guide to those in health professions planning, policy and education.

Louis W. Sullivan

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Executive Summary

The Robert Wood Johnson Foundation provided funds to the Morehouse School of Medicine to conduct a study of the trends in black health professional manpower, the education of black health professionals, and the special role of minority schools in educating black health professionals in the United States.

Background

Historic Overview

- During the early 1960s, two major social policy directions converged: "health care as a basic right for all Americans" and the Civil Rights movement.
- A series of federal programs in affirmative action, civil rights, and in health care was developed in the 1960s and early 1970s, to improve access to care for all, to improve access to care for minorities, and to expand the supply of health manpower, including minority health manpower. These programs reached their zenith in the mid-seventies.
- Since 1981, the philosophy of less federal intervention in social programs and civil rights has emerged. Reductions in federal support have placed increasing financial strains on higher education institutions and students, particularly those students from low and lower-middle income families. These factors, combined with the slowing of enrollment of minority students--particularly blacks--in health professions schools, which began in the mid-seventies, presage further erosion of the minority manpower gains made during the sixties and seventies.
- The gains, however, never approached the goals of parity with whites, in the ratios of manpower to population nor in enrollment.
- Until the late 1960s and early 1970s, the vast majority of black health professionals were educated at predominantly black health professions schools. As the number of majority schools and student enrollment increased, there was a shift in the proportion of black students enrolled in majority and minority schools. In medicine the proportion of blacks graduating from minority schools declined from one-half of the graduates to less than one-quarter. In pharmacy, dentistry and veterinary medicine, the change was less striking.
- In the last several years, there has been an increase again in the proportion of blacks attending the minority medical schools.
- It is clear from the data in this study, that the minority health professions schools play a critical role in the education of black health professionals.

Health Status of the Minority Population

- Concerns about health manpower and minority health manpower are based on the relationships between access to care and health status and the influence of health care on health status--death, disability and illness. The non-white population constitutes almost one-third of the population in health manpower shortage areas, in contrast to non-shortage areas where non-whites comprise 15 percent of the population. In urban shortage areas non-whites constitute 47 percent of the population.

- Urban blacks are more likely than urban whites to be without a regular source of care, and blacks travel for a longer time to get care. Outpatient departments and emergency rooms are a more frequent source of care for blacks than for whites.

- Since the advent of Medicare, Medicaid, and the social programs of the 1960s, there has been considerable improvement in the health status of the population-at-large and the health status of blacks. However, there are still striking differences between whites and blacks for a number of key health status indicators:

  - Life expectancy for non-whites is approximately five years shorter than for whites.

  - Low birthweight infants and very low birthweight infants are more numerous among blacks than whites, with infant mortality for blacks almost double that of whites.

  - Blacks have a higher incidence of, and higher death rates from, hypertension, strokes, and certain types of cancer.

- The disparity between black and white utilization of dental care is even greater than the racial disparity in the use of medical care.

Trends in Health Manpower and Black Health Manpower

- The U.S. Department of Health and Human Services has projected the proportion of black health professionals to population needed to achieve parity with total health professionals to population for the year 2000. In medicine, dentistry, and pharmacy, the projections show a substantial deviation from the goal.

  - In medicine the black physician to black population ratio would be less than one-half the physician to population ratio for whites.

  - In dentistry the black ratios will be less than half the white ratios.

  - In pharmacy the black ratios will be less than 60 percent of the white ratios.

  - Similar data are not available in veterinary medicine but black veterinarians constitute only 1.6 percent of total veterinarian manpower.

- A number of factors are affecting all health professional institutions which can substantially change the Department of Health and Human Services projections. These are:

  - Decline in the total applicant pool in most health professional fields, yet a slight increase in minority applicants in medicine. In dentistry the most recent data show an increase in black applicants after a decline between 1977 and 1979.

  - Decline in the college-age population, but a continuing increase in the proportion of blacks attending college. (This increase may be abating. Data are not available on the trends in two-year and four-year colleges.)

  - Reductions in federal financial aid programs for undergraduate and graduate students; blacks, many of whom come from lower income families, are heavily dependent on student aid.

  - Perceptions of surpluses of manpower in certain health professional fields and related efforts to reduce class size and total enrollment.

  - Slowed growth in federal and state funding for health professions schools.

  - Retrenchment in federal affirmative action programs and insufficient commitment to increased black enrollment by a majority of predominantly white institutions.

Students and Faculty

- Beginning in the mid-sixties, there were large increases in student enrollment in medicine, dentistry, pharmacy, and veterinary medicine. Black medical students increased substantially as a proportion of total medical students; lesser gains were made in the other health professions.

- The percentage increases in black enrollment peaked in medicine and dentistry in the mid-seventies and then declined. Recently there has been a slight increase but not to the levels of the peak years.

- In pharmacy, baccalaureate enrollment has continued to rise but the number and percent of graduates peaked in 1978-79. In veterinary medicine black enrollment remained at the same percentage of total enrollment between the mid-seventies and the present.

  - Of the 127 medical schools in the United States, the four minority medical schools (Meharry Medical School, Howard University, Morehouse School of Medicine and the Charles Drew Medical School) educate almost one-quarter of the black physicians.

  - Meharry and Howard Dental Schools educate almost 38 percent of the black dentists. There are 58 dental schools in the U.S.
  - The four minority pharmacy schools (Florida A & M, Howard University, Texas Southern and Xavier University) educate more than 45 percent of the black pharmacists. There are 71 pharmacy schools in the U.S.
  - Tuskegee Institute educates three-quarters of the black veterinarians. There are 23 schools of veterinary medicine in the U.S.

o The success of majority schools in increasing black enrollment varies widely. Some institutions have achieved notable progress and others, particularly some state universities in areas with large black populations, have black acceptance rates and enrollments significantly below the national average.

o There is a substantial underrepresentation of blacks as faculty members at health professions schools in all fields. In medical schools, there have been modest increases in the percentage of black faculty and a shift of black faculty between minority and majority schools, with an increasing proportion teaching in majority schools. In dental schools the proportion of black faculty is higher than in medicine. In pharmacy, black faculty constitutes three percent of total faculty, and in veterinary medicine the proportion is very small.

Student Financing

o Several characteristics of black health professions students distinguish them from white students in terms of student financing.

  - Black students come from lower income families than whites with a disproportionate number coming from families with incomes under $20,000 per year.
  - Black students tend to be older than white students and often have families of their own.
  - Black health professions students have a higher probability than whites of entering health professions schools with debts already accrued from their undergraduate education.

o Current federal student aid policies are making it more difficult for minority students to enter and continue health professions education. Black students graduate with an average education debt higher than whites. Average educational debt is rising.

o There has been a five-fold increase in the number of students obtaining Health Education Assistance Loans (HEAL) with interest rates exceeding 13 percent. Guaranteed Student Loans (GSL) at lower interest rates are limited to $5,000 per year, substantially below the level needed to finance health professions education.

- There has been a substantial decrease in the availability of National Health Service Corps Scholarships. National Direct Student Loans and Exceptional Financial Need Scholarships have also declined.

- Rising tuition and the concomitant increased need for financial assistance are particularly acute problems for minority students. The reduction in scholarships and the growing reliance on HEAL loans with market rate interest will become increasing impediments to maintaining or expanding black participation in health professions education, particularly for low-income students.

Minority Educational Institutions and Their Financing

- Even with the expansion of black student enrollment in majority schools during the sixties and seventies, the minority health professions schools still educate three-quarters of the black veterinarians, almost one-half of the black pharmacists, more than one-third of the black dentists, and one-quarter of the black physicians.

  - The financing of the minority schools differs significantly from most majority schools. Except for Howard University (a federally funded institution) most of the minority schools have histories of financial fragility.

  - Because their missions have been to educate black professionals and because their student bodies generally come from low-income families, private endowments have never been a major source of funding.

  - Except for some unique arrangements with a few states, the private minority schools have not received regular state appropriations.

  - Because of their orientation toward the education mission, they have not received significant biomedical research grants, which serve as a major financial resource for many majority schools. None of the minority schools in the study is a major research institution.

  - Finally because of their location in low-income areas and their limited access to clinical facilities, the ability of the minority schools to generate income from patient care services is more limited than most majority institutions. Patient care revenues have been the most rapidly increasing source of support for majority schools.

  - Minority schools are less likely than majority schools to have affiliations with large Veterans Administration and county hospitals. These affiliations provide substantial clinical faculty support for majority schools.

  - The private minority health professions schools remain financially vulnerable and as federal and state support shrinks, their vulnerability will increase.

Problems

Enrollment and Retention of Students

The literature cites a number of barriers to increased enrollment, retention and graduation of black health professionals.

- Acceptance to application rates for blacks have fallen while they have risen for whites. These rates vary widely among institutions.

- Admissions criteria clearly influence acceptance rates. Some schools heavily weight the health professions admissions tests and grade point averages while others use additional criteria such as clinical interest. Blacks tend to score lower on standardized admissions examinations. The reasons for this have long been debated by sociologists, anthropologists and policy analysts. There is evidence that these tests at best are predictive of success in the basic science curriculum. They are not predictive of success in clinical curriculum or practice.

- There is evidence that many minority students are poorly prepared in the sciences in high schools and colleges and do not receive appropriate counselling for health professions careers.

- Lack of role models is also frequently cited as a barrier to increasing black health professions students.

- Socioeconomic factors clearly influence the ability of students to attend college and professional schools. Changes in student financing with a shift from scholarships to loans, and an economic recession will increase the difficulty of black students in financing the long health professions education process.

- The Bakke decision is often cited as a stimulus to relax affirmative action efforts. There has been a significant retrenchment in support of affirmative action goals and programs.

- The minority health education institutions which educate a significant proportion of minority health professionals are facing increased financial difficulty for several reasons:

    - Lack of biomedical research support and potential reduction in federal support of biomedical research.

    - Lack of the scope and diversity of clinical facilities for support of clinical faculty combined with location of the clinical facilities in low income areas.

    - Limit on ability to increase tuition levels because of the large proportion of low income students attending minority schools.

    - Potential reductions in state support as state revenues decline.

    - Reduction in federal support for health professions educational institutions.

Issues and Options

The report raises a series of issues and options regarding an increase in black health manpower in an era of manpower surplus, the reasons the goals of increased black health manpower were not achieved, the need for minority schools, the need for a federal role, and options for policy makers to consider:

- o While there may be an emerging surplus of health manpower in many fields, there is no surplus of black health manpower, and wide disparities will continue between the ratio of black manpower to black population and white manpower to white population. Many health manpower shortage areas and underserved areas have large black populations. Health status measures for blacks are worse than for whites.

- o Since the federal government bears much of the cost of health care, it must be concerned about access to care and health status, since improved health status should translate into lower health and social expenditures.

- o An increase in the proportion of black health professionals is dependent on a number of factors:

  - Commitment of majority health professions education institutions.

  - Admissions and retention policies of majority institutions.

  - Improved high school and college science training for black students.

  - Affordable student financing.

- o The data show that only a very small proportion of majority health professions schools is responsible for increases in black student enrollment. Strategies to broaden this base include:

  - Strong commitment by governors, state legislators and state higher education boards to ensure that state universities implement policies to increase black enrollment.

  - Increased scholarships and low interest loans to black students.

  - A more aggressive federal policy of enforcement of civil rights and affirmative action programs.

  - Training of more minority faculty and minority faculty development.

- In all fields minority schools play a critical role in the maintenance of total minority enrollment. Any cutbacks in enrollment in minority health professions schools will reduce total black enrollment and black health professions manpower.

- The minority schools are more financially vulnerable than the majority schools. To strengthen these schools financially some policy options could be undertaken to:

  - Provide funds for approved biomedical and health services research grant applications designed to address significant health problems of minority population groups, utilizing the unique strengths and perspectives of minority health professions schools.

  - Provide funds for health manpower project grants designed to increase the capacity of minority and majority health professions schools to identify, recruit, educate and train more minority health professionals.

  - Increase recruitment of minority students by the Armed Services and the proportion of Armed Services scholarships going to minority students.

  - Promote affiliations between hospitals supported by governmental agencies (federal, state, county and city) and minority health professions schools in their geographic area.

Conclusion

There is a substantial probability that previous gains in the increase of black participation in the health professions will be eroded during the eighties unless action is taken to:

- Increase minority student financial support through scholarships and low interest loans.

- Increase the commitment of majority schools to recruit and retain black students, even if the schools reduce general enrollment.

- Restore enrollment at Meharry to at least 100 students per class in medicine as soon as possible and expand the Morehouse class size to reach their goal of 64 students per class.

- Increase the financial stability of the minority health professions schools by expanding their clinical bases, particularly through new or enhanced VA and county/city hospital affiliations.

- Develop a sufficiently strong research base at minority health professions schools to attract strong basic science faculty, including more minority faculty.

Introduction

The Robert Wood Johnson Foundation provided funds to the Morehouse School of Medicine in November 1982 to conduct a three-month study of black health professional manpower, black health professional education, and the special role of minority schools in educating black health professionals in the United States.* The study is based on existing data.

The purposes of the study were:

- To describe the health status of the black population and the role of the black health professional in improving health status of the black population
- To describe past and projected trends in the size of the black health professional manpower pool
- To describe the trends in enrollment of black students in health professions schools
- To describe demographic, social and economic factors affecting the trends
- To describe the role of the minority schools in educating black health professionals and the differences between majority and minority student financing and the financial stability of the minority schools
- To raise policy issues related to the size of the pool of black health professionals and the role of minority schools in the future
- To offer for consideration policy options for the federal government, states, and the private sector.

In 1978, the Macy Foundation commissioned Dr. Charles E. Odegaard to direct a study on minorities in medicine during the decade 1966-76.1/ Odegaard was one of the first commentators to observe and identify the early warning signs of retrenchment of progress at the very end of the period covered in his study. The findings of the present study confirm Odegaard's predictions of retrenchment.

This retrenchment may be further exacerbated by the perceptions of policy makers, health professionals and their organizations that there is an emerging surplus of health manpower, particularly in medicine and dentistry. Although the Graduate Medical Education National Advisory Committee (GMENAC) concluded that there was an emerging surplus of physician manpower, they also stated that this surplus did not include minority health manpower where increases were still needed.2/

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* The Johnson Foundation grant supported the studies of medicine, dentistry, and pharmacy. The Principal Investigator donated the time for the study of veterinary medicine.

BACKGROUND

Historic Overview [3]

During the early 1960s two major social policy directions converged: "health care as a basic right for all Americans" and the civil rights movement. The development of the Medicare and Medicaid programs stimulated concerns that the supply of health manpower would be inadequate to meet the need and demand for health care services of the poor and elderly, many of whom were minorities. Civil rights proponents and others were concerned about discrimination at all levels of society, including the education system and the low representation of minorities in the professions and at the majority universities. Until the mid-sixties an overwhelming proportion of black health professionals was trained at schools created especially to educate minorities.

A series of federal programs in affirmative action, civil rights and in health care was developed to improve access to care for all, to improve access to care for minorities and to expand the supply of health manpower including minority health manpower. In 1963 for the first time, the federal government provided direct aid to all health professions schools to expand their programs, an ideal opportunity to expand minority enrollment. The federal government actively developed programs to support health professions education institutions and students including construction grants, institutional support and capitation, special project grants and scholarship and loan programs. Some of this support was targeted to increase the proportion of minority students, for example, the Health Careers Opportunity Program.

In addition to direct support to institutions and students, two indirect sources of support were growing rapidly. Biomedical research funding enabled medical schools and, to a lesser extent, other health professions schools to support faculty who devoted part of their time to research and part of their time to instruction. The size of the faculty and the diversity of specialties could then be increased. Biomedical research funding increased very rapidly until the late 1970s. Secondly, the development of Medicare and Medicaid provided a new source of funding for residency programs and clinical faculty. (Hospital reimbursement formulas include salaries of residents and costs of supervision of residents. Medicare also allows teaching physicians to bill fees for services they provide to patients. Hospital revenues and practice plan revenues are a growing source of support for medical schools and, to a lesser extent, for schools of dentistry and pharmacy.)

During the same period affirmative action pressures to increase minority student enrollment and minority faculty were placed on universities. Many of the health professions education associations developed special programs to encourage minority enrollment, most notably the Association of American Medical Colleges (AAMC).

Civil rights, the commitments to health as a right, access to care for the poor and to an increase in health manpower and minority health manpower reached their zenith in the mid-seventies. Civil rights activities and affirmative action policies in higher education lagged behind those in other areas, particularly after the Bakke case; however, as Odegaard and others have commented, enthusiasm and energetic support for the policies began to wane by the late 1970s. In the late 1970s the federal government began to reduce direct support of health professions education and to slow the increases in the Medicare-Medicaid programs. During this period there was also a growing perception that the nation had moved from a shortage of health manpower to a surplus, although minority manpower still lagged well behind the goals of the sixties and seventies. With the change in administration in 1981, the philosophy of reduced federal intervention in social programs and civil rights emerged.

Federal cutbacks also have placed increasing financial strains on higher education institutions and students, particularly those from low and lower-middle income families. These factors, combined with the slowing of the enrollment of minority students--particularly blacks--in health professions schools and the impact of the 1978 Bakke decision [47] presage further erosion of the gains made during the sixties and seventies. The gains, however, never approached the goals of parity* with whites, in the number of black students in the fields of medicine, dentistry, pharmacy and veterinary medicine.

Until the late 1960s and early 1970s the vast majority of black health professionals were trained at predominantly black health professions schools. These schools included Howard University and Meharry Medical College in Medicine and Dentistry, Howard University, Xavier University of Louisiana, Florida A & M University, and Texas Southern University in Pharmacy and Tuskegee Institute in Veterinary Medicine.

As the number of majority schools and enrollment increased, there was a shift in the proportion of black students enrolled in majority and minority schools. Majority schools increased their proportion of black students substantially at the expense of the minority schools. In medicine the proportion of blacks graduating from minority schools declined from half of the graduates to less than one-quarter. Although these shifts also occurred in all fields, the change was less striking. In the last several years there has been an increase again in the proportion of blacks attending the minority medical schools. (See Appendix 2 and Table 1.)

It is clear from the data and trends in the data that the minority health professions schools play a critical role in the education of black health professionals. Without an increase in acceptance rates of black students at majority health professions schools, reduced enrollments in minority schools would have a significant negative effect on the pool of future black health professionals. In medicine the recent cutbacks in enrollment at Meharry Medical School recommended by the Liaison Committee on Medical Education** were partially offset by the enrollment in the new minority schools, Morehouse and Charles Drew, and not by the increase in minority enrollment in majority schools.

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* Parity in this context and throughout this document means proportionate parity, i.e., percentage of black health manpower to equal the percentage of the black population as white manpower to white population.

** The Liaison Committee on Medical Education (LCME) is the accrediting body for medical schools. The clinical facilities for education at Meharry Medical College, discussed later in this report, were the major cause of concern.

Concerns about health manpower and minority health manpower stem from perceptions that health status can be improved through medical care intervention and that access to care and to certain types of care influence health status--death, disability and illness.

Health Status of the Minority Population

Data are not available linking black population, health professional manpower, health underserved areas and health status.* In fact, an analysis is needed in the future that will compare underserved populations, total physician and other health manpower and minority health professions manpower and the location and practice sites of minority and majority manpower.

A recent paper prepared by Berk, Bernstein and Taylor of the National Center for Health Services Research, however, provides some interesting data on socio-economic and racial differences in health manpower shortage areas.5/ There were significant differences in income of the population in shortage areas in contrast to non-shortage areas, with residents of shortage areas at lower income levels. Major racial differences were also observed with non-whites constituting almost one-third of the shortage area population in contrast to only 15 percent living in the non-shortage areas. The authors stated that the racial differential was particularly large in urban areas where more than 47 percent of the population in urban shortage areas were non-white. Regional differences were also found with residents of the South more likely than residents of other regions to be located in shortage areas.

Other indicators further describe the disparity between shortage and non-shortage areas:

- Residents of shortage areas were more likely to perceive their health as fair or poor
- They were more likely to be uninsured
- A large percentage were Medicaid recipients
- There was less disparity among all populations having no physician visits
- The populations of underserved areas were less likely to report a usual source of care
- About 15 percent of residents in shortage areas traveled thirty minutes or more for care and even longer in rural areas as compared to approximately 20 minutes or less travel in non-shortage areas
- About 29 percent of residents of rural shortage areas did not see a physician even though they perceived their health as fair or poor, contrasted to 14 percent in rural non-shortage areas.6/

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* The Commonwealth Fund has awarded a grant to the Association of American Medical Colleges (AAMC) to study the location and type of practice of black medical school graduates of the class of 1975. The principal investigators are Stephen Keith, Al Williams and Augustus Swanson.

The authors conclude that when looking at a number of variables such as income, racial background and lack of health insurance coverage, the designation of manpower shortage areas and physician-to-population ratios is not as significant, although it is important in the determination of health status.7/

Since the advent of Medicare, Medicaid and the social programs of the 1960s there has been considerable improvement in the health status of the population at-large and the health status of blacks. However, there are still striking differences between whites and blacks for a number of key health status indicators. Life expectancy for whites of both sexes is approximately five years longer than for non-whites. (See Table 2.) While non-white life span has increased proportionately, it still lags behind the span for whites. Low birthweight infants and very low birthweight infants are more numerous among blacks than whites with infant mortality almost double that of whites. (See Tables 3 and 4.) Blacks have a higher incidence of hypertension, strokes, and deaths from certain types of cancer than whites. (See Table 5.)

Urban blacks are more likely than urban whites to be without a regular source of care and blacks travel for a longer time to get care. (See Table 6.) Satisfaction with care is lower for blacks than for all other groups. Thirty-five percent of blacks in the rural South and Hispanics in the Southwest did not see a physician in a one-year period and 61 percent of urban blacks and 82 percent of rural Southern blacks did not see a dentist. Among blacks, 63.5 percent as contrasted to 83.7 percent of whites saw a physician in his office with 20.1 percent of blacks using emergency rooms and outpatient departments of hospitals as primary sources of care, and less than 10 percent of whites using these sources. (See Table 7.)

Although differences in utilization of physicians' services have narrowed since the 1960s, blacks continue to have fewer physician visits, substantially fewer dental visits and for blacks with incomes under $10,000, a high number of hospital days per year. (See Tables 8, 9, and 10.) For most health status indicators the black health indicators are worse than those for whites. The data on dental care show even greater differences between black and white populations.

A number of commentators argue that access to medical care and use of medical services may not be the major factors in improving health status. Income, education, housing and environment play a larger role. It is clear that health status and access to care are worse for blacks than for whites, that a higher proportion of blacks than whites lives in health manpower shortage areas and a higher proportion of blacks receivestheir care from hospital outpatient departments rather than physicians' offices.

Trends in Health Manpower and Black Health Manpower

Physician Manpower

In the 1980 Census black Americans account for 11.7 percent of the total population, a rise of slightly more than one-half of one percent in the last decade. To achieve parity, obviously, the proportion of black physicians to total physicians would have to reach 11.7 percent. However, in 1980 black physicians accounted for 2.6 percent of practicing physicians. (See Appendix 1 and Table 11.)

Based on projections made in 1982 by the Health Resources Administration,[8/] although the supply of black U.S.-trained M.D.s will double, the number will still fall substantially short of parity by the year 2000. The projections are that the number of active black M.D.s will grow from the current 11,700 to between 23,100 to 28,700 by the year 2000. The black physician to black population ratio would then be one physician per 1420 or one to 1140 respectively or less than one-half the physician to population ratio of white physicians to white population. Obviously, white physicians, Hispanic, black and Asian physicians do not and should not serve only their own ethnic and racial populations, but where there are large concentrated ethnic and racial populations, it is less likely that physicians from other ethnic and racial groups will locate practices in these areas as a first choice. The projections indicate that under the most optimistic set of assumptions there will be 37,000 fewer black practitioners than needed to achieve parity. By the year 2000, the nation will produce less than half the black physicians needed to equal physician to population ratios for whites.

A number of changes could reduce the most favorable black physician projections. These include:

- Decreased enrollments in all schools which result in decreased black enrollment
- Continuing reduction in acceptance rates for blacks in majority schools
- Continuation of the LCME imposed reduction in enrollment at Meharry
- Failure to reach future enrollment goals at Morehouse and Charles Drew, two new minority medical schools.

An increase in enrollments to a level close to parity would require a number of actions:

- A major increase in the number of black applicants and in the acceptance rates for blacks at majority schools
- Increased enrollments in all of the minority medical schools (requiring the development of larger clinical bases at Meharry and Morehouse)
- Special programs to retrain black allied health professionals
- Sustained concerted efforts to reach black students during high school to encourage them to enter the health professions and to provide a strong academic base to compete at the high school and college level.

Dental Manpower

While some progress has been made in increasing the supply of black physician manpower, there has been somewhat less progress in achieving increases in dental manpower. Estimates are that in 1980 black dentists constituted 2.9 percent of all active dentists in the United States, a slightly higher percentage than in medicine. There is one dentist per 1795 persons in the U.S. but only one black dentist for every 7297 blacks in the population. (See Table 12.)

The Health Resources Administration's projections are that under the most favorable assumptions the number of black dentists would increase from 3630 in 1980 to 7350 in the year 2000. To achieve parity an additional 15,500 dentists would need to be trained. (See Appendix 1.)

It should be noted that utilization of dental care for blacks is much lower than for whites. The differences in use of services by race is greater for dental care than for medical care.

Recent developments in dental education may have further adverse effects on increasing the supply of black dental manpower: a decline in the pool of applicants to dental schools and perceptions by the practicing dental community and dental educators that an oversupply of dentists exists or is emerging. However, if Howard and Meharry can maintain their enrollment levels and continue to graduate 38.4 percent of black dentists, or more than 70 black students, the effect may be an increase in the proportion of black dental manpower in relation to the total dental manpower pool. In contrast, if the majority dental schools continue to decrease enrollments, it may have an adverse effect on the numbers of black students enrolled given their lower acceptance rates relative to whites.

Pharmacy Manpower

It would be expected that since pharmacy as a profession requires a less protracted and costly educational program, there would be a larger number of black pharmacists than physicians or dentists. Black pharmacists in 1980 constituted only 2.3 percent of all practicing pharmacists in the United States. (See Table 13.) Black dentists and physicians represented larger percentages of their manpower groups than pharmacists. (See Appendix 1.) In many areas of the country where there is a shortage of physicians, clinical pharmacists often serve as a primary care provider of service. Many of the pharmacy graduates of the minority schools serve these areas.

According to the Health Resources Administration's projections, under the most favorable assumptions,[9] black pharmacists will number 8480, or 4.7 percent of total pharmacists in the year 2000, leaving a shortfall of 14,220 needed for parity.

Veterinary Medicine

Data on blacks in veterinary medicine are gathered from a very small sample and may be subject to a large estimating error.

Census data from 1980 show that black veterinarians constitute only 1.6 percent of the total veterinarian manpower. (See Table 14.) Black enrollment in schools of veterinary medicine has hovered between 1.9 percent and 2.1 percent of total enrollment. (See Tables 15 and 16.) Tuskegee Institute, one of 23 U.S. institutions training doctors of veterinary medicine, educates approximately three-quarters of all black veterinarians in the United States.

Several factors are affecting all health professions institutions at this time, some of which lead to optimistic and some to pessimistic predictions about the feasibility of an increase in the black health manpower pool during the next decade. These factors, which will be discussed in greater detail in later sections of the report, include:

- Decline in the applicant pool in most health professional fields, yet a slight increase in the minority pool in medicine and maintenance of the pool in dentistry
- Decline in the college-age population during the next decade and lower than parity black enrollment in colleges, but a continuing increase in the proportion of blacks attending college. (This factor may be changing. Recent anecdotal information for the 1982-83 academic year suggests a decline in black enrollment.)
- Reductions in federal student financial aid programs for undergraduate and graduate students and in the special health professions student programs; blacks are heavily dependent on these programs at the undergraduate and graduate levels
- Perceptions of surpluses or emerging surpluses of manpower in certain fields by some health professions manpower organizations and efforts by some professions to reduce the size of health professions school classes
- Slowed growth and reduction in federal and state funding for health professions schools--both direct and indirect sources of financing
- Retrenchment in federal civil rights and affirmative action programs and insufficient commitment to increased black enrollment by a majority of predominantly white institutions of higher education in the health professions.

Students and Faculty

Students

Beginning in the mid-sixties there were large increases in enrollment in medicine, dentistry, pharmacy and veterinary medicine. Black medical students increased substantially as a proportion of total medical students; lesser gains were made in other health professions. The percentage increases in black enrollment as a percentage of total enrollment peaked in all fields in the mid-seventies and then declined. Recently there has been a slight increase in medicine and dentistry but the levels attained in the peak years have not been reached again. An increasing number of black students attend majority schools although in dentistry, veterinary medicine and pharmacy the minority schools continue to educate a large percentage of black students. In medicine the shift in black enrollment from the minority to the majority schools has shown a tendency for reversal in the last few years. (Detailed enrollment data are presented in Appendix 2.)

The success of majority schools in increasing enrollment of blacks varies widely. Some institutions have achieved notable progress and others, particularly some state universities in areas with large black populations, have black acceptance rates and enrollments below the national average. A number of factors, discussed later in the report, suggest there are differences in the degree of commitment to the goal of increased minority health manpower. (Data on the differences are shown in Appendix 2.)

Some variables related to the applicant pool are highly influential in achievement of the goal of increased enrollment and graduation of black health professionals. These factors include the pool of college graduates, professional school acceptance criteria and potential applicant exposure to role models.

The size and characteristics of the potential applicant pools for blacks and whites differ substantially. Although the percentage of black students attending institutions of higher education as full-time undergraduates has increased dramatically from 6.0 percent of the total in 1968-69 to 10.0 percent of the total in 1980-81, black enrollment has not reached parity with that of the white population. (See Table 17.)

Medicine

Enrollment in medical schools rose faster than enrollment in higher education institutions. (See Appendix 2.) The rapid expansion of medical schools and medical school enrollment provided a unique opportunity to increase the proportion of black students without reducing total enrollment for other groups. Although there were substantial increases in blacks attending college and absolute gains were made for black medical students, they are not comparable to the gains made in higher education for blacks or in white acceptances to medical schools. Blacks constitute 10.0 percent of the students in higher education institutions and 5.9 percent of students in medical schools in 1981. Whites constitute 79.6 percent of the students in institutions of higher education and 86.0 percent of the enrollment in medical schools. In 1970-71 whites constituted 89.4 percent of enrollment in institutions of higher education and 94.3 percent of the enrollment in medical schools. (See Tables 17 and 18.)

Reasons for the differences in the gains made by blacks in institutions of higher education in contrast to medical schools are not readily explained.

Applicant to acceptance ratios are critical factors in increasing enrollment of specific population groups. The applicant to acceptance ratios for blacks fell until the mid-seventies and have risen since that time. (See Tables 19 and 20 and Appendix 2.) Surveys indicate that a larger proportion of minority students at institutions of higher education aspire to be physicians than non-minority students. (See Table 21 and Appendix 2.)

There is some evidence that preparation in basic sciences at the undergraduate college level and at the high school level[10] is a factor in both acceptance to medical school and to success rates in medical school. Medical College Aptitude Test (MCAT) scores (the entry exam taken by medical students) tend to be lower for blacks than for whites; there is a similar situation with college aptitude tests.[11] The reasons for the difference have been debated extensively by anthropologists, psychologists, sociologists and educators who cite such factors as educational disadvantages, cultural bias in the tests, etc. Black medical students are substantially more likely than whites to encounter difficulties with coursework and to be required to repeat courses. (See Table 22.) This is particularly true of the first year of medical school in which there is a heavy basic science concentration.[12]

Various individuals in discussion of this phenomenon tend to attribute the problem to poor college and pre-college preparation of minority students in the basic sciences. (Such preparation is vital for the strong science orientation and intensive nature of medical education, although the necessity for the current degree of rigor is under review.)

Residencies in Medicine

Until recently, blacks constituted a smaller proportion of the total resident pool than black medical school graduates due to the high percentage of foreign medical graduates in U.S. residency programs. (See Tables 23 and 24.) However, there are not adequate data on the differences in the types of residency programs (integrated, non-integrated) and the affiliation status of the hospital to the medical school.

The distribution of black residents differs from that of whites in that there are higher proportions of black residents in obstetrics/gynecology, pediatrics, public health, neurological surgery and radiology (except nuclear medicine).

Dentistry

The number of black dental students also peaked in the mid-seventies and then declined. The most recent data show an increase, but not to the level of the mid-seventies. (See Appendix 2.)

The factors affecting black enrollment in dental schools are similar to those in medicine. In addition, dentistry is perceived as a less attractive field among black and white students for a number of reasons. There is a perceived surplus of dentists and dental school graduates are finding it difficult to start practice. The cost of establishing a dental practice is higher than for medicine and the future earnings potential is lower. Fewer people are covered by dental insurance than by medical insurance and dental care financing is more sensitive to general economic trends than medical care.

For blacks, who tend to serve lower income populations, earnings potential is much lower than in medicine. Engineering and computer science tend to attract the same pool of students as in dentistry and when these fields are experiencing upswings, dentistry tends to be seen as less attractive.13/ The opportunity costs are also influential. Engineering and computer science degrees can be achieved in 4-5 years post-high school while dentistry requires 8 years of training.

While surveys of students show a higher proportion of students aspiring to be physicians than dentists and a higher proportion of black students than other students who want to be physicians, the reverse is true in dentistry. Fewer students aspire to be dentists and fewer black students than other student groups aspire to a career in dentistry. (See Table 21.)

As in the case of medicine, there are wide variations in acceptance and retention rates of black students among the majority schools.14/

Pharmacy

Although the length of training in pharmacy is shorter than in medicine, fewer black students are enrolled in schools of pharmacy than in schools of medicine both in absolute numbers and as a proportion of pharmacy enrollment. The graduate figures are also lower. Proportionately, fewer black students than whites are enrolled in the Pharm D programs and Ph.D. programs. According to the American Association of Colleges of Pharmacy, in 1980, among a total enrollment of 464 in Pharm D programs, there were 18 blacks. Pharm D total enrollment in 1981 was 525, with 25 blacks constituting 4.7 percent of total Pharm D enrollment. The one predominantly black school, Florida A&M, with a Pharm D program, had more than half of the black Pharm D enrollment. Texas Southern has received approval for a Pharm D program. A much higher proportion of black pharmacy students attend minority pharmacy schools than in medicine or dentistry, but minority schools in pharmacy constitute a larger proportion of the total institutions than in medicine or dentistry. The four minority pharmacy schools, Howard, Florida A&M, Texas Southern and Xavier, graduate almost half of the black baccalaureate pharmacists in the U.S. Only one of the minority schools, Florida A&M, has a Pharm D program and only one, Florida A&M, offers a masters degree program.15/

A smaller percentage of college freshmen indicate pharmacy as a preferred profession than the other health professions with a higher percentage of whites than blacks aspiring to become pharmacists. (See Table 21.)

There are no data available on applicant to acceptance ratios. In the last several years applications and enrollments in schools of pharmacy have declined. The AAHC impact study cited competition from engineering, computer sciences and business administration and salary levels which have not risen in recent years as factors contributing to declining pharmacy enrollment. In 1975-76 white enrollment reached a peak of 20,729 and declined to 17,603 in 1981-82. However, black enrollment and total minority enrollment have increased slightly. Black enrollment rose from 915 in 1975-76 to 958 in 1979-80, but then declined to 932 in 1980-81. (See Table 25.) Enrollment of all students also declined.

Veterinary Medicine

Historically, Tuskegee Institute has educated most of the black veterinarians in the United States as well as veterinarians for the Caribbean Islands and some African countries. Although there are now 23 schools of veterinary medicine in the U.S., to this day Tuskegee educates three-quarters of all black veterinarians. (See Table 15.)

Of all the health professions, veterinary medicine has the least representation of blacks with blacks constituting 2.1 percent of enrolled students. In 1981-82, of the 179 black students enrolled in all schools of veterinary medicine, 137 attended Tuskegee. Black enrollment has risen from 96 in 1971-72 to 179 in 1981-82. The application per student rate is higher for blacks than for whites, but the difference is not as great as in dentistry and medicine. However, the acceptance rate is higher for blacks at Tuskegee than all schools combined. (See Table 26.)

In the surveys of college freshmen a much lower number of blacks indicates an interest in veterinary medicine than in medicine, dentistry, and pharmacy. (See Table 21.)

Faculty

There is a plethora of opinion and literature regarding the importance of role models in influencing career choices. Important factors include contact of children and young adults with professionals, teachers and counsellors in the same ethnic and racial group. As the data have shown, blacks are less likely to have as frequent contact with black health professionals as whites have with white professionals, since blacks are underrepresented in all of the health professions. There is also substantial underrepresentation of blacks as faculty members of health professions schools and as high school and college science teachers and counsellors. In medical schools there have been very modest increases in the percentage of black faculty. During the last ten years there has been a shift of black faculty between minority and majority schools with an increasing proportion teaching in majority schools.

Race specific data are not available for all fields. Available data are discussed in Appendix 2.

Distribution of black faculty in medicine by specialty shows comparative underrepresentation in the basic sciences. It should be noted that it is in the basic sciences that black students do less well on the entrance examinations than whites and have higher repeat rates in medical school.

In the clinical sciences black faculty in obstetrics, public health and psychiatry exceed the representation of non-black faculty in those fields. (See Table 27.) Representation is much lower than average in dermatology, internal medicine, neurology, ophthalmology and otolaryngology. This pattern of representation also appears for specialty choice of residents.

In dental schools the proportion of black faculty is higher than in medicine and has increased by 34 percent between 1976 and 1981. (See Table 28.) Unpublished data from the American Association of Colleges of Pharmacy indicate that during academic years 1981-82 and 1982-83 there were 63 full-time black faculty, or 3 percent of all pharmacy school faculty, in U.S. colleges of pharmacy. The majority of black faculty members hold positions at the predominantly black schools of pharmacy.16/ In veterinary medical schools the proportion of black faculty is small except at Tuskegee. (See Table 29.)

Student Financing

Average family income of minorities, particularly blacks and Hispanics, falls below the national median. In addition, minority families tend to be larger than white families (in 1977 mean size of family for whites was 3.27, for blacks it was 3.76)17/, thus increasing the financial burden on these families in terms of expenditures for higher education. By every measure: family income, educational status of families, professional status of families, role models for students in the community and in high schools, colleges and universities, the majority of blacks and Hispanics start from a more disadvantaged base than the majority of whites.

Some economists have maintained that financing even through high interest loans should not be a deterrent to students enrolling in health professions schools, particularly medicine. They believe the future earnings potential more than compensates for high debt and loss of current earnings. One such recent study by The Urban Institute 18/ indicated that its findings might be modified for minority groups. The policy thrust of the study was such that unless the differences in the impact of financing on majority and minority students are clearly articulated, decisions to shift financing more and more toward market interest rate loans might find additional support. If the policy thrust discussed in The Urban Institute study (which is already in effect) is maintained, the ability of a large proportion of black students to pursue studies in medicine, dentistry, veterinary medicine and probably pharmacy would be damaged. According to a 1974 analysis of college freshmen prepared by the American Council on Education 19/, and other studies cited throughout this document, several characteristics of black health professions students distinguish them from white students:

- Black students come from lower income families with a disproportionate number coming from families with incomes under $20,000 per year
- They tend to be older than their white counterparts and often have families of their own
- They have a higher probability of entering health professions schools with debts already accrued from their undergraduate education
- Career choices to date show that many of the black students in medicine will choose lower paying specialties like pediatrics and public health and will practice in less affluent areas and public hospitals.

The National Institute of Independent Colleges and Universities studied recent trends in financial aid 20/. While many of the findings are general, they can be extrapolated to minority students when combined with other findings.

The study found that the number of undergraduate aid recipients from families with incomes below $24,000 declined by 39 percent between 1980 and 1981. The independent sector "private" colleges are experiencing a loss of students from this income category. Many black undergraduate colleges are "independent" colleges and serve as major "feeders" into both majority and minority health professions schools. This decrease in students could affect the future applicant pools of the health professions.

To quote from the study, "While student aid reports no longer require identification of aid recipients by race, thereby making it impossible to get an accurate count of minority recipients, there is nevertheless an indication that minority participation declined in the two-year span." 21/

In a study of graduate and professional students who applied for need-based financial aid in 1980-81, the findings for lower income and minority students are striking. 22/ Key factors highlighted by the study were:

- Students applying as college seniors for need-based aid for the first year of professional school were already receiving aid to complete college
- Medical and law students, as contrasted to graduate students in other fields, relied more heavily on loans. More than one-half of the medical students used loans with little or no subsidy, "thus contributing to the substantial debt burden of medical students." 23/
- For all graduate students in 1981 those with the heaviest debt were the private school medical students who had borrowed on average $31,000 by their fourth year of medical school. Those at public medical schools had borrowed $21,000. In some minority schools in the survey conducted as part of this study, many students were at this debt level by the end of the second year.
- Black students at public and private graduate schools "were aided particularly by the College-Work Study program" 24/ and the National Direct Student Loan Program.
- "Data from the present study indicate that minority group aid applicants are considerably more likely to come from low-income families than are their non-minority counterparts. Some 62 percent of black college seniors came from families with parental incomes of less than $10,000, compared to 25 percent of the white college seniors. If access to the Guaranteed Student Loan (GSL) program is discontinued, it is doubtful whether the more than one-third of the minority students relying on GSL in the present study could have financed their graduate education in 1979-80 or whether the 60-80 percent of the minority students who participated in one or more of the federal self-help student aid programs in 1979-80 could have pursued their education..." 25/

It should be noted that loans from GSL are limited to $5,000 per year. Tuitions in private medical schools exceed this amount. Students at the surveyed minority schools have been turning to the non-subsidized Health Education Assistance Loans (HEAL) to augment the GSLs.

In a paper on issues in Financing Minority Medical Enrollment,[26/] Dr. Leon Johnson, Jr., highlights some of the problems which are becoming more severe as a result of current federal student aid policies. For example, a larger proportion of minority students in 1980-81 interrupted their medical education than majority students. Minority students had greater indebtedness and there was a shift from scholarships to loans. (See Appendix 3.)

Dental student data are available for 1980, before the advent of recent major changes in federal financing. These data show that black dental students enter dental school with a debt two-and-one-half times higher than that of whites and higher than all other minority students. They graduate with a mean indebtedness of more than $19,000, which is higher than that for whites but lower than other minorities. (See Table 30.) Table 31 shows data for all students in dental school by type of financial support.

Of even greater importance in the ability of minority students to attend health professions schools is the interest rate on the student loans. Johnson found that in 1981-82 the distribution of borrowing of minorities was:

Distribution of Borrowing
of Minorities 1981-82

% of Students	Loan Type	Interest Rate
91	Graduate Student Loan	7%
54	Health Professions Student Loan	3%
22	National Direct Student Loan	5%
25	Health Education Assistance Loans	19%

According to Dr. Johnson, there was a fivefold increase in the number of students who borrowed from HEAL between 1980-81 and 1981-82. While the interest rates have dropped in 1982-83, they still exceed 13 percent.

It has been estimated that a $10,000 HEAL loan at 18% interest with a ten-year repayment plan beginning 8 years after receipt of the loan would total over $85,000 in repayment costs. At 14% under the same assumptions a $10,000 loan would translate into $55,000 repayment burden. 27/

Many of the minority schools in this survey showed a substantial increase in HEAL loans, although the schools are discouraging these loans until the final year of school. One-third of the first-year students and two-thirds of the second-year students at Morehouse and one-fifth of the first-year students and one-third of the second-year students at Meharry had HEAL loans in 1981. More than one-third of all medical and dental students at Meharry this year have HEAL loans.

In its annual medical education issue, the Journal of the American Medical Association (JAMA)28/ shows the changes in student aid between 1980-81 and 1981-82. (See Table 32.) However, data are not provided by race. The findings are that although the rate of growth in aid decreased, there has been a substantial increase in the total amount of student aid with major shifts in the sources of aid. Eighty-four percent of the aid was federally sponsored. 29/ Guaranteed Student Loans continued to provide the most dollars. HEAL loans rose most rapidly as a percentage of all loans. There was a substantial decrease in National Health Service Corps Scholarships. National Direct Student Loans and Exceptional Financial Need Scholarships also declined. "The most alarming trend is the more than 100% increase in HEAL loans, for which students are charged about 17% annual interest." 30/

The data from the minority schools study show a similar trend with major increases in the HEAL loans.

The JAMA study also reported a rise in mean educational indebtedness from $18,000 in 1980-81 to $20,000 in 1981-82. The number of students with debts exceeding $20,000 rose almost 45 percent during the same period.

Rising tuitions and the increasing need for financial assistance is a particularly acute problem for minority students. The shrinkage of National Health Service Corps Scholarships and the Exceptional Financial Need Program and the increased reliance on HEAL loans with market rate interest will become increasing impediments to maintaining or expanding black participation in health professions education, particularly for low-income students. In minority schools in this study, a very large proportion of students in 1980-81 came from low-income families. (See Appendix 3.)

Anecdotal data developed from student interviews conducted during this study indicate that some students in the private minority schools who are pressed financially are attempting to transfer to state institutions.

As the data show, the minority schools play a major role in the education of minority health professionals. It has also been shown that minority students are experiencing increasing financial difficulty in pursuing an education in the health professions. The ability of the minority schools to maintain their missions depends on their financial viability which is based on support from tuition and other sources.

Minority Educational Institutions and Their Financing

Until the early 1970s the minority health professions schools were the main resources for education of minorities entering the health professions. With the expansion of enrollment in majority schools during the sixties and seventies, there was an increase in enrollment of minority students in majority institutions. However, even with this shift and affirmative action pressure, the minority health professions schools still educate three-quarters of black veterinarians, almost half of the black pharmacists, more than one-third of the black dentists and one-quarter of the black physicians.

Except for Howard University (a federally funded institution), Charles Drew, a private school which receives support from the state and county, and two black pharmacy schools which are part of state university systems, the remaining minority health professions schools are private schools with histories of financial fragility. Because their missions have been to educate black professionals and because their student bodies come from low-income families, private endowments have never been a major source of financing for the black health professions schools. In addition, except for some unique arrangements with a few states, the private schools have not received regular state appropriations. Also because of their education rather than research orientation, they have not received significant biomedical research grants which serve as a major financial resource for many other schools. Finally, because of their location in low-income areas and their limited access to clinical facilities, the ability of the minority schools to generate income from patient care is more limited than for most majority institutions.

The results of these factors are that the private minority health professions schools remain financially vulnerable and as federal and state support shrinks, their vulnerability will increase. The comparatively low socioeconomic status of students enrolled at the minority health professions schools obviates the possibility of raising tuition to compensate for the loss of state and federal funding. As part of this study a survey was conducted of the revenues of the minority schools. (Howard University, a federally funded institution, is not included in this study.) These data for the medical schools have been compared with revenues shown in the recent annual medical education survey of the American Medical Association and Association of American Medical Colleges 31/ and with the six majority institutions studied by the Association of Academic Health Centers.32/ (See Appendix 4 and Tables 33 and 34 for data and detailed discussion.)

As the data in Appendix 4 show, financing for the minority health professions schools, except for the two state-sponsored schools, differs significantly from the financing of the majority schools. In medicine, dentistry, and pharmacy, two major factors account for the difference: biomedical research funding and patient care funding. In veterinary medicine the issue is private versus public schools. Most schools of veterinary medicine are part of state land-grant colleges and even private schools receive considerable state support.

Medicine

None of the minority medical schools in this study is a major research institution. Two of the three schools are new and have not had an opportunity during their short existence to develop a research base. Furthermore, one school does not yet have a clinical base and one does not have a strong enough clinical base to mount major clinical research programs. On average, biomedical research provides one-fifth of the revenues of majority schools and contributes substantially to faculty salaries.

The most rapidly growing source of financing for majority medical schools has been patient care revenues. There are four main sources of these revenues: payments from hospitals and clinics for supervision of residents and administration of patient care services; fees to teaching physicians for direct provision of services to individual patients; salary support by hospitals of residents who contribute a substantial amount of clinical teaching to undergraduate students; and finally a majority of medical schools have affiliations with large acute care Veterans Administration (VA) hospitals. Staff of the hospitals usually have faculty appointments with portions of their salaries borne by the medical schools and the VA. VA salary support enables the medical schools to augment their clinical faculty resources.

Of the three minority medical schools in this study, only one school has a strong clinical base, with a county hospital providing some support for clinical faculty. One medical school owns its hospital, which has been in financial difficulty due in part to low patient census and a high proportion of low-income patients in a city with excess hospital beds. The hospital, unlike most medical-school-owned hospitals, is not a tertiary care facility. The third school which is developing its clinical programs at this time does not have access to a major clinical facility in close proximity. In the case of the latter two medical schools there are acute care VA facilities in the cities in which the schools are located and there are also major county-owned facilities. However, in both cases majority medical schools located in the same cities have the affiliations with both county and VA hospitals. Both minority medical schools have had to seek VA affiliations in other communities. One facility is a two-and-one-half hour drive from the medical school and the other is located in the suburb of the city and is mainly a chronic disease rather than an acute care facility.

A further problem is inherent in the socioeconomic status of the black population and in the location of the schools in urban low-income areas. While these same factors affect majority schools, majority schools tend to have more clinical affiliations with hospitals that serve large groups of middle-income patients and are able to generate considerable faculty support from medical practice plans.

Charles Drew, a private school, operates on an entirely different basis than the other two medical schools studied. Even though it is a private school, it has a unique relationship to the University of California System. In collaboration with the University of California at Los Angeles, students enrolled at Charles Drew receive basic science instruction at UCLA. The clinical base is a county-supported hospital with clinical faculty salaries paid in part by the county hospital. In addition, the institution receives substantial state support. However, with the recent cuts in Medicare and Medicaid support, the county hospital has become vulnerable.

Dentistry

In dentistry, the one school in the study was Meharry, which is more heavily dependent on tuition than most other dental schools. Problems with the clinical base, similar to the medical schools, were noted.

Pharmacy

In recent years there has been an increased emphasis on clinical pharmacy skills; drug prescription and utilization, and counselling of patients on drug use and dosage. Hospitals and clinics are critical education components of pharmacy education. Many schools of pharmacy derive faculty support for clinical pharmacy functions performed in hospitals and clinics. None of the minority schools derives revenue from this source.

Veterinary Medicine

In veterinary medicine state support is critical. The vast majority of veterinary schools are state land-grant colleges. With the opening of new state schools there has been an erosion of support by states which previously had interstate agreements with Tuskegee but now have their own institutions. For example, Tuskegee has lost interstate funds from Virginia and Maryland, yet the new Virginia school has accepted very few black students from Virginia and Maryland. Tuskegee is a national resource since it has educated three-quarters of the black veterinarians in the United States and draws students from all parts of the nation. Increased hospital and clinic revenue, an expanding source of support for many veterinary schools, is a less likely source of growth for Tuskegee because of its geographic location in a low-income rural area.

Problems

Enrollment and Retention of Students

Black enrollment in health professions education has never approached parity with whites. Based on projections of the Department of Health and Human Services, enrollment will reach less than half of a parity goal by the year 2000. The goal of parity is probably unrealistic and will remain so until blacks achieve parity at the four-year college level. While enrollment of black students at institutions of higher education has risen at a rapid rate and has reached 10 percent of the college population, this increase in black representation has not risen as dramatically in the health professions schools.

The literature cites a number of barriers to increased enrollment, retention and graduation of black health professionals. Most of the literature focuses on medicine; however, many of the findings for medicine are applicable to the other professions.

The published findings can be summarized into the following topics:

- Admissions criteria
- Academic preparation
- Role models
- Socioeconomic background
- Affirmative action and leadership by the majority schools.

The Association of American Medical Colleges in a report issued in June 1978, addressed a number of these issues and made a series of recommendations particularly on the pool of minority applicants, preparation, financing and faculty.34/

Admissions Criteria

In 1969 seventy-five percent of all blacks applying to medical schools were accepted. The AAMC assumed that a high acceptance rate would continue and that an increase in black applicants would result in an increase in students and graduates.35/, 36/ This assumption was not realized. Increases in the years 1970-71 to 1975-76 were only half of what was needed 37/ to meet the AAMC's goal of 12 percent black enrollment in the freshman class in 1975-76. The black acceptance rate had fallen to 43.9 percent in 1973-74, to a low of 39.4 percent in 1979-80, and in 1980-81 was 40.7 percent. The non-minority acceptance rate in contrast has risen from 34.7 percent in 1973-74 to 47.9 percent in 1980-81. (See Table 19.)

The acceptance rate for black students in different institutions varies widely. Some institutions, for example the University of North Carolina, have had a consistently good record in recent years. Other institutions in the same geographic region have had less impressive records.

Johnson states, "In 1974-75 U.S. medical schools accepted minorities at a rate 9.7 percent higher than they accepted non-minorities.....However, by 1977-78 minorities were being accepted at a rate of only 1 percent greater than non-minorities....By 1981-82 the non-minority rate had increased to 5.2 percent,"38/ greater than the minority rate. Johnson noted that 23 of the 126 medical schools (including the minority institutions), accounted for 50 percent of black student enrollment. The drop in minority enrollment was also cited by Odegaard.39/ A contributing factor to the drop in minority enrollment may have been the Bakke decision.

In June 1978, in a landmark case, the Supreme Court of the United States ruled against the University of California-Davis in favor of Alan Bakke.40/ The Supreme Court found that the admissions system of the University of California-Davis, whose goal was to increase minority enrollment, was illegal. Black freshman enrollment at all medical schools as a percentage of total freshman enrollment had peaked at 7.5 percent in the 1974-75 academic year but had held fairly constant at about 6.7 percent since 1975-76. In the fall of

1978 it dropped to 6.4 percent. The slide may have been the result of decisions made by cautious medical school admission committees while the Bakke suit worked its way through the courts. Many felt that the Bakke decision was a symbol of retreat from the 1960s' commitment to racial equality and weakened the 1954 Supreme Court's Brown vs. Board of Education decision which held that racially separate education was inherently unequal.41/ Many educators believe the Bakke decision gave the colleges an excuse to relax their affirmative action efforts.42/

The criteria for admission clearly influence the acceptance rates. These criteria in general are MCAT scores, grade point averages and other factors which individual schools regard as predictive of future academic and practice success. Wellington and Montero 43/ found that schools which broadened admissions criteria, which previously had been heavily weighted for grade point averages and MCAT scores, were successful in increasing black enrollment. There is little evidence that candidates with the highest scores on the MCATs will be better physicians. At best, MCATs are predictive of success in the basic sciences curriculum.44/

One of the major contributing factors to the lower scores of blacks on standardized tests is that these instruments are based on the structure and content of education available at secondary schools and colleges with a preponderance of white middle-income students.45/ According to Geiger and Seidel,46/ admission to medical school is based heavily on social class. Dr. Robert Graham, the Administrator of the Health Resources and Services Administration, has stated, "Despite their low scores, these students (minorities) manage to catch up and within four years they are scoring in the mid-range of National Board examinations of clinical competency."47/

According to the Chairman of AAMC's Minority Affairs Section, the MCAT does not consider different cognitive processes and speed. Many minority students perceive the test as an aptitude test and do not prepare for it. In fact, it is an achievement test.48/

It should be noted that use of the MCAT scores without consideration of other factors has been criticized for other reasons.49/, 50/ It is felt that overemphasis of science relative to humanistic skills and inadequate measures of clinical problem solving abilities may fail to recognize the applicant possessing the interest and characteristics needed in primary care practice.51/, 52/

Some schools give extra weight to applicants who are minorities, come from rural areas and/or are economically disadvantaged and express interest in primary care. The AAMC has recommended improvement of interviews as an admissions tool and the use of the simulated Minority Admissions Exercises 53/ in the application process. There are, however, some commentators who believe modified rating criteria will lead to a second class of practitioner who will not compete for desirable positions, leading to a racial/class physician hierarchy.54/, 55/

Academic Preparation

A number of commentators claim that minority students are poorly prepared in the sciences and that their reading and analytic skills are not sufficiently well developed in high school and college. High school recruiters have reported widespread perception by minority students and their teachers that a college education is not a realistic possibility for low-income and minority students.56/,57/ More than half of the minority students in the nation fail to graduate from high school.58/

In interviews with health professions students during the course of this study, a number indicated that poor counselling, particularly in high school, steered the students away from the "hard" mathematics and science curricula to "soft" courses and, in many cases, to non-college preparation courses. This tendency to discourage science concentration was often continued in college.59/,60/,61/

The AAMC Task Force on Minority Student Opportunities in Medicine recommended that medical schools improve communication with undergraduate advisors and faculty, provide leadership in assisting in undergraduate pre-medical education, offer activities at the high school level to orient minority students and stress the value and importance of minority college programs.62/

Role Models

Lack of role models is frequently cited as a barrier to increasing the proportion of black health professions students.63/ A study of medical students and graduates from 1971-74 found that blacks made their career decisions later than whites.64/ Family doctors, local physicians and relatives in medicine who usually serve as role models for majority students are underrepresented as role models for black students, while teachers and peer groups increase in influence over that for black students. It is obvious from the proportion of black professionals to total professionals in the population that contact with black physicians and other health professionals is less likely than the contact of white students with white health professionals.

While the AAMC Task Force report recommended increased funding for faculty development programs, the data have shown there are relatively few black faculty members in medicine, dentistry, pharmacy and veterinary medicine. Alternative role models, such as high school and college teachers and high school and college counsellors, therefore, become important.

Socioeconomic Factors

National income data consistently show black family income to be below the median for whites. A 1974 survey of freshmen aspiring to careers in the health professions found that blacks came from the lowest income backgrounds with family income half that of whites.65/ Black students were less likely to report that their parents were college graduates, although their mothers more frequently had college educations than their fathers. Only about one-half as many blacks as whites had fathers in the health field. Black health career aspirants tended to be slightly older than whites, were more likely to attend private rather than public colleges and to attend colleges in the South. Blacks were twice as likely as whites to report financing as a major concern and relied more heavily on federal student aid programs than whites to finance their undergraduate education.

This same survey identified traits for the four professions: in medicine and dentistry blacks tended to be older than their white counterparts and their income status was half that of whites. Those aspiring to the pharmacy profession came from the lowest socioeconomic status of the four fields with one-third (in 1974) reporting incomes under $6000. In veterinary medicine blacks reported higher parental incomes than in the other fields and were more likely to have mothers with advanced degrees. The majority of blacks surveyed in all fields were deeply concerned over their ability to pay for their education and were heavily dependent on federal grant and loan programs.

The data from the survey conducted for this study show a high proportion of students in all four professions from families with incomes under $20,000 and a very large proportion in families with incomes under $10,000.

Affirmative Action

Large gains in minority enrollment were made in the early seventies. In the four-year period between 1968 and 1972 most medical schools and other health professions schools initiated programs to increase minority group enrollment. Many of the programs, such as the University of Illinois Medical Opportunity Program, achieved significant success.66/

Wellington and Montero found that schools which broadened their admissions policies and provided special tutoring and academic support programs were most successful in increasing minority enrollment.67/ Those schools with successful programs continue to recruit minority students. The year 1977 appears to have been the high watermark in the proportion of blacks attending health professions schools (total enrollment) with the peak of acceptances in 1974-75. There has been an upward turn again in 1981-82, but it has not reached the high mark of 1977. The AAMC Task Force Report on Minority Student Opportunities in Medicine notes that since the late 1960s and early 1970s there has been a marked change in the social environment which affects efforts to increase minority student opportunities. The study states that increased inflation and a tightening job market have probably contributed to a decrease in support for affirmative action activities. The report also cites decreased student activism.68/ The Bakke decision in 1978 may have legitimated inactivity. However, Odegaard and others found indications of slippage in commitments prior to the Supreme Court decision.69/,70/,71/

A review of the latest data from the medical education issue of JAMA shows the continued wide variation in total black enrollment.72/ (See Table 35.)

It is interesting to note that many of the public health professions institutions in states with large black populations have black enrollments below the national average, while a number of non-minority private schools have higher black enrollments.

In all health professions (although most strikingly in veterinary medicine) the role of the minority schools is a significant one. It should be noted that in medicine, dentistry, veterinary medicine and to a lesser extent in pharmacy, the minority health professions schools educate students from virtually all states in the union, and cannot be regarded only as "state" or "regional" resources. If there were no minority schools and if the status quo of enrollment in majority schools was maintained, black enrollment in medicine would be 4.6 percent of the total, in dentistry 2.3 percent, in pharmacy 2.1 percent, and less than 1 percent in veterinary medicine.

Financing of the Minority Health Professions Schools

As has been shown, the financing of the minority health professions schools differs substantially from the majority schools. Sources of revenue are less diverse and some minority schools derive little revenue from biomedical research.

The ability of the minority schools to develop major research programs is limited by the slowed growth of federal biomedical research funding, which has lagged behind the increased costs of such research. Commentators like Challenor 73/ believe that the institutions that already have large biomedical research programs will capture a growing share of the federal biomedical research dollar.

Patient care revenue is a lesser source of revenue in all minority health professions schools. Clinical revenues remain a problem in two of the three medical schools, the dental and the pharmacy schools. Hospital and clinic revenues, a substantial source of revenue for majority schools, currently contribute few funds to minority schools. The low socioeconomic status of patients cared for by faculty of minority medical schools make practice plan revenue a smaller potential source of revenue for these schools.

Unless the clinical base for Meharry and Morehouse can be strengthened by affiliations with local public hospitals and VA hospitals and unless the patient load at Meharry's own hospital can be increased, achieving the desired increase in student enrollment will be difficult, if not impossible.

For minority pharmacy schools the most acute financing problem lies in the one private school, Xavier, which receives no state support. Unlike the majority schools none of the schools receives support from hospitals and clinics. Biomedical research support is minimal. For all the pharmacy schools the development of strong clinical affiliations is essential to develop a comprehensive clinical pharmacy curriculum, to increase clinical pharmacy faculty, to provide clinical experience for students and to develop and enhance Pharm D and graduate programs.

The financial problems of many of the minority institutions also have implications for their ability to compete for faculty. With fewer biomedical and patient care resources than majority schools, the ability to attract new faculty and faculty with substantial biomedical research support or clinical income is limited. Thus a circular problem is in operation. Previous successful competition for past projects and a base for future projects are essential preconditions for attracting biomedical research funds and researchers. In times of constrained biomedical research dollars, attracting these resources to build a base becomes increasingly difficult on a competitive grant basis.

In clinical sciences the problem is both less and more acute. It is less acute in the sense that physician and dental clinicians can more easily develop a patient care base than researchers. It is more acute because clinicians' salaries and expected remuneration in the specialties and subspecialties are high and cannot be guaranteed by the minority schools. Furthermore, the hospital clinical base for the minority medical/dental schools is limited and nonexistent for the pharmacy schools. Competition for clinical revenue is growing and two of the minority medical schools are located near prestigious majority schools. The location of the minority schools in urban low-income areas makes them especially vulnerable to cutbacks in patient care programs for the elderly and the poor. Finally, the lack of strong, major VA affiliations affects both the research and clinical programs for medicine, dentistry and pharmacy.

A countervailing influence in medicine and dentistry is the rapidly increasing supply of physicians and dentists and a slowing of the expansion of schools and faculty. This factor will make it more difficult for young faculty to choose locations and may increase the pool of faculty available to the minority schools.

Tuition and state funding constitute more significant sources of funds for minority schools. The significance of tuition, combined with the socioeconomic status of the students at the minority schools, leaves the schools with little flexibility in using tuition as a source of increased financing. If the recent cutback in enrollment at Meharry is maintained, it may lead not only to long-term erosion in the number of blacks attending medical school, but deprive the school of tuition revenue.

Issues and Options

A number of policy issues have been raised regarding further efforts to increase the supply of black health professionals. For some of these issues, there are gaps in information which need to be filled before definitive conclusions on policy directions can be reached. For other issues social philosophy and concepts of social justice and equity will guide decision makers. Finally, for some issues existing data clarify the issue and lead to fairly direct conclusions. This section of the report will raise several key issues, describe the adequacy and appropriateness of data to address each issue, and provide some possible options for policy makers to consider. The issues are posed in the form of questions:

In light of an emerging consensus of a future health manpower surplus, why should society and the federal government be concerned with the issue of black health manpower?

This issue can only be partially addressed by data, but also involves issues of equality of opportunity and social justice. The demographic and health status data show that the health status of the black population is worse than that of whites; that blacks constitute a higher proportion of the population in federally-designated health manpower shortage areas and that blacks more heavily utilize outpatient hospital services in lieu of private physicians' offices than whites. In dental care, use rates are substantially lower for blacks than whites. While recent data show that distribution of health manpower has widened substantially, health professionals still attempt to locate in more affluent socioeconomic areas, suburbs, etc. A comparison of the ratios of manpower-to-population continues to show wide disparities in southeastern rural areas and inner city areas. Use of outpatient services in county hospitals and certain university hospitals is rising, suggesting a decline in access to private practice physicians.

Society and the federal government bear the costs of health care through Medicare and Medicaid, private insurance and government sponsored facilities. Improving the health status of minorities should translate into lower health expenditures, fewer disability and welfare benefits and increased productivity. Access to early care is dependent on manpower availability.*

After fifteen to twenty years of civil rights and affirmative action policies, why hasn't there been a greater increase in the proportion of black health professionals?

A number of factors previously discussed in this report affect admissions and retention of students:

- Commitment of the health professions schools to increase black student enrollment. The evidence of differences in admission and retention rates among institutions indicates that some institutions still have not developed effective programs. Some state university systems, particularly those in northeastern and southeastern states with large black populations, stand out as failing to recruit black students.

- Applicant pool. While the black college pool has expanded rapidly, it has not yet reached parity with the white population. For the 1982-83 academic year many colleges have reported a decline in the number of black enrollees. In minority colleges, first-year enrollment has dropped 12 percent. The health professions education process is a long one and there is a time lag between the increase in undergraduate enrollment and graduate school attendance. However, it should be noted that the increase in black undergraduate enrollment has risen faster than the black enrollment in health professions schools. It should also be noted that as the white applicant pool has dropped significantly in medicine and dentistry, the black pool has increased slightly, but the white acceptance rates have risen.

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* Additional data and data analysis are needed on the practice location patterns of black physicians and dentists compared to white physicians and dentists.

- Admissions criteria. In all of the health professions schools great weight is given to standardized entrance examinations. In medicine, and probably in dentistry and veterinary medicine as well, there is little evidence that these entrance exams are predictive of success in clinical studies or clinical practice. There is considerable evidence that schools which utilize additional criteria are more successful in recruiting, retaining and graduating black health professions students.

- Poor high school and college training. There is an extensive body of literature demonstrating that minority students receive weak science, reading and analytic training from elementary school onward. In addition, there are anecdotal data that many minority students are actually counselled away from the more difficult academic courses in high schools and colleges. A large proportion of minority students are from low socioeconomic status families and families where parents are more likely to have not completed high school.

- Lack of role models. This is a "Catch 22" problem. Without an increase in the numbers of black health professionals, young people are less likely to have contact with role models in the health field. Educational enrichment and guidance from their families are less likely for black students than for groups with higher socioeconomic and educational status. Strong stimulus from teachers, community leaders and other role models is vitally important. Special efforts are needed by black health professionals to reach out to the high schools and colleges. More concern needs to be addressed to the adequacy of training for high school and college teachers and counsellors.

- Student financing. With the recent changes in federal policy to reduce programs like the National Health Service Corps Scholarships and Graduate Student Loans, students from low-income families are experiencing serious financial difficulties and are turning to non-subsidized HEAL loans to finance their education. Black students are also more likely than whites to have accrued debt for undergraduate education. There has been a shift in at least one minority school to students from higher-income families. There is evidence that black students are more likely than whites to interrupt their education for financial reasons. Scholarships and subsidized loans are essential to maintaining and increasing black enrollment. It is too early to assess the impact of rising unemployment among black families on enrollment in colleges and health professions schools.

Shouldn't the focus be on the majority schools to encourage enrollment of blacks in health professions schools?

It is clear from the data that some majority schools (in all fields but veterinary medicine) have achieved success in recruitment, retention and graduation of minority students. It is also obvious from the data that a very small proportion of majority schools is responsible for increases in black student enrollment. The preponderance of health professions schools has made little progress in increasing minority enrollment.

For example, in medicine there are 127 schools. In 1981-82 about 23 percent of the black enrollment was in the four minority schools, and an additional 33 percent was in 21 majority schools, i.e., less than 20 percent of the schools educated 56 percent of the black students. (See Tables 18 and 35.) In dentistry and pharmacy the percentages are even more disproportionate, and Tuskegee still educates 75 percent of black veterinary medical students. It appears unlikely that majority schools will significantly increase their efforts in minority enrollment without strong external incentives.

Strategies which might be utilized to encourage majority schools to increase their minority enrollment and retention (particularly in states with large black populations) include:

- Strong commitment by governors, state legislators and state higher education board to ensure that the state universities implement policies (including admissions criteria) to increase black enrollment.
- Increased scholarships and low interest loans to black students.
- Commitment by the leadership of the academic health institution associations to the goal of increased black enrollment, including better evaluation of admissions criteria, stimulation of minority recruitment programs, etc.
- Reversal of the current federal policy of civil rights and affirmative action enforcement.
- Training of minority faculty, faculty development and support of minority institutions.

In all fields, however, the minority schools play a critical role in the maintenance of enrollment. The cutbacks in enrollment at Meharry are likely to contribute to a decline in black enrollment in medicine in 1982-83. (Data will be available in April 1983).

In dentistry, two minority schools are responsible for more than one-third of all black graduates. In pharmacy, four minority schools out of a total of 71 institutions, graduate more than 45 percent of the black pharmacy graduates. It would require large increases by the majority schools to equal the role played by the minority schools.

Why should there be minority schools?

The rationale for minority schools is similar to that for schools sponsored by religious groups where students can learn in an environment where they are not the minority but the majority. In some majority schools where blacks constitute less than five percent of the enrollment, some black students do well. In some cases in these institutions there is a history of insensitivity to the needs of black students as well as the black community. Many black students do not function well in such environments and prefer the option of schools where there is a history of experience, sensitivity, and relevance to black history, culture and the needs of black people as students, patients, or as a community.

In addition to the needs of students, minority schools have a special sensitivity, experience and commitment to the unmet needs of blacks and similar underserved communities. A large proportion of their students go on to practice in these communities and many of the students are drawn from these communities.

The choice and pluralism for black and white students available with the existence of minority and majority schools is consonant with the choice and pluralism that reflect the political environment in the United States. It is also basic to what education at its best is about--a variety of education institutions public and private, large and small, religious and sectarian, majority and minority.

Why should there be a federal role?

The response to this question requires a combination of political philosophy and data and is similar to the issue of why there should be a federal role in education, in higher education, in health--What is a public versus a private good? What are the roles of the federal government and the states in social policy?

Rather than addressing the issue philosophically, there are pragmatic factors which can provide guidance.

- The federal government finances a large percentage of the nation's health care expenditures. Therefore, it has a responsibility to ensure that its dollars are spent wisely.
- Black health status is worse than whites' health status. Premature death and disability lead to large social costs in lost productivity and increased demands on federal and state income security programs and publicly-sponsored health programs.
- Despite recent adverse decisions in civil rights, the federal government remains constitutionally committed to equality of opportunity.

Can private philanthropy meet the needs of black health professions education?

Recent public policy statements have suggested that private philanthropy could take up the slack of reduced federal participation in social programs. The evidence to date is that the amount of funds required to substitute for federal dollars is so large that there is no probability that private funds could substitute for the totality of public funds. With the current recession and growth in need in all social areas, it is highly unlikely that private funds, which cannot approach current needs, can be used to completely support the programs needed to increase black enrollment in the health professions.

This is not to suggest that private support should not be sought to finance innovative programs, scholarships for low-income students and biomedical research. However, it is unrealistic to suggest that private funds could substitute for all public funds.

If the impact of cuts in federal funds are not yet endangering majority schools, why are minority schools endangered?

At present not all minority schools are endangered. Florida A & M and Texas Southern (the two state pharmacy schools) and Charles Drew Medical School are in reasonably stable financial positions as long as the public commitment continues.

The remaining minority schools, as discussed earlier, have less diverse sources of financing than the majority schools, do not have a biomedical research funding base and have vulnerable and less than adequate clinical bases.

Furthermore, where these schools provide patient care services, they serve low-income populations and populations less likely to have private health insurance. While some majority schools have similar patient bases, they frequently have additional clinical resources which assist in cross-subsidizing no-pay or low-pay patient care services.

Finally, the recent changes in Medicare reimbursement for hospitals and the expected regulation of payment of teaching physicians may make a number of majority schools fiscally vulnerable in 1983 and 1984.

What can the federal government do that doesn't require legislation to target more resources to minority schools?

There are few options short of new legislation that could assist these institutions. Several actions might be considered to:

- Increase funds available for approved biomedical and health services research programs based at minority schools.
- Give minority schools priority on special project grants designed to increase minority health manpower, i.e., family practice, etc.
- Increase the recruitment of minority students by the armed services and the proportion of Armed Services Scholarships going to minority students. The Armed Services heavily weight the MCAT scores. A change in criteria could increase the number of minority students selected.
- Require the VA to share affiliation of its major acute care hospitals in Nashville (Meharry) and in Atlanta (Morehouse).

Note: County government could also intervene to ensure minority school participation in patient care in Nashville's and Atlanta's county hospitals.

If Howard is a federally-supported institution, why can't Howard be expanded to meet all the needs?

While some expansion of Howard might be feasible, absorbing the total enrollment of all the minority health professions schools would not be practical for the following reasons:

- Massive capital investment in classrooms and laboratories would be needed. Absorption of the expanded enrollment would require more than doubling the enrollment in medicine and dentistry, vastly enlarging the enrollment in pharmacy and developing a new school of veterinary medicine. In addition, there would be significant costs associated with recruiting and moving faculty to accommodate the expansion in student enrollment.

- The creation of additional clinical facilities in a geographic area that is already overbedded and has a high concentration of health professions schools would be expensive.

- Costs would be transferred from the states to the federal government. Some states now make capitation payments to the private minority schools and the states provide appropriations to the state schools. If all students attended Howard and the other minority schools terminated their programs, states would not provide education support.

- Costs would also be transferred from the private sector to the public sector through tuition differentials.

Conclusion

Before the era of expansion of social programs and civil rights activism, which began in the 1960s, black health professionals constituted only a very small percentage of the health professions manpower pool. Most of the black health professionals were educated at the minority schools and very few graduated from the majority schools.

Beginning in the late 1960s major efforts were made to increase black enrollment. Entry into the health professions in the 1960s and 1970s and enrollment of black students increased in all fields. The records of majority schools in expanding enrollment varied widely even during the height of interest in, and support for, expanding educational opportunities. In the mid-seventies the increase in black enrollments slowed and the acceptance rates, in contrast to the white acceptance rates, declined. The decline in acceptance rates has continued to date. The minority schools of dentistry, pharmacy and veterinary medicine continued to educate a substantial proportion of black health professionals. The minority medical schools, which until the mid-seventies educated a declining proportion of black students, are once again playing a more prominent role in educating blacks. Deterrents to increased enrollment in majority schools include lower standardized test scores and grade point averages for blacks than whites; heavy weighting of standardized test scores in contrast to other admissions criteria; few role models and higher rates of attrition for blacks than for whites.

Recent changes in student financing are increasing the already considerable economic barriers to black health professions students who tend to come from families with lower socioeconomic status than white students. The black students are also more likely to incur considerable debts in the pursuit of their undergraduate education than white students.

The minority health professions schools, particularly the private schools, have a less diverse and a weaker financial base than the majority schools. They are less likely to derive revenues from biomedical research grants. Their clinical bases too, are much weaker in terms of the scope of facilities, the number of clinical affiliations and the size and payment status of the patient population. Patient care revenues have been the most rapidly growing source of revenue for the majority medical schools, and constitute some funding for majority pharmacy schools, but not for minority schools. Many majority schools have strong affiliations with Veterans Administration acute care hospitals and county hospitals in close proximity to the schools. Not so for the minority medical schools. Even though county hospitals exist in several of the cities in which minority medical schools are located, with the exception of Charles Drew, they are not strongly affiliated with the county hospitals. In the case of affiliations with nearby VA hospitals, frequently this affiliation has been filled by a local majority medical school, requiring students of the minority medical school to travel further afield for their clinical experience. This factor also affects faculty support.

There is a substantial probability that previous gains in increased black participation in the health professions will be eroded during the eighties unless action is taken to:

- Increase financial support through scholarships and low interest loans. The AAMC Task Force recommended increases in limits on Graduate Student Loans, per year and in total; extension of the repayment period and increases in Exceptional Financial Need Scholarships.
- Increase the commitment of the majority schools to recruit and retain black students even if they reduce enrollments in general.
- Restore enrollment at Meharry to at least 100 students per class in medicine and rapidly expand the Morehouse class size to reach the original goal of 64 students per class.
- Increase the financial stability of the minority health professions schools by expanding their clinical bases, particularly via new or enhanced VA and county hospital affiliations.
- Develop a sufficiently strong research base to attract strong basic science faculty.

The study was based on existing data. During the course of the study gaps in the data were identified which should be collected in future studies:

- Current data on student financial aid for all health professions fields, for all students and by race and ethnic group
- Data on type and location of practice by race and ethnic group
- Data on type of institution (university hospital, county hospital; integrated, non-integrated programs) where graduate medical and dental education is undertaken, by race and ethnic group
- Additional analysis of the impact of high debt on attrition, on the choice of graduate program, and on choice of practice specialty
- More detailed analysis of potential financial resources for minority students
- More detailed studies of underserved areas and type of health professionals serving these areas, including specialty distribution.

Appendix 1

Background

In 1970-71 there were 180 black graduates from U.S. medical schools; 94, or 52.2 percent were graduated from Howard University and Meharry Medical College. By 1972-73 minority schools accounted for 36.7 percent of black graduates. (See Table 36.) From 1969-70 to 1972-73 first-year enrollment increased in all medical schools by 31.2 percent and black enrollment more than doubled. Between 1973 and 1982 first-year enrollment in medical schools increased by an additional 22 percent but black enrollment increased by only 15.8 percent. The proportion of black medical students in minority schools increased from 17.6 percent in 1974-75 to 23.7 percent of black students in 1981-82. (See Table 1.) The experience of black student enrollment in the majority schools of dentistry, pharmacy and veterinary medicine has been less successful.

In 1979-80, 38.4 percent of black dental school graduates were from Howard University and Meharry Medical College. (See Table 37.) Black enrollment in the four minority pharmacy schools in 1981-82 was 38.1 percent in contrast to 57.1 percent in 1971-72. Approximately three-quarters of black veterinary medical students attend Tuskegee Institute. (See Tables 15 and 25.)

Trends in Health Manpower and Black Health Manpower

Physician Manpower

The data indicate that black physicians in 1980 constituted 2.6 percent of all practicing physicians and 3.3 percent of U.S.-trained physicians (excluding those trained in foreign countries). (See Table 11.) More striking are the ratios of white physicians and black physicians to white population and black population. There are 20.2 white physicians per 10,000 white population and 4.2 black physicians per 10,000 blacks. This equates to one white physician for 490 whites and one black physician for every 2,380 blacks. There has been only modest improvement in the percentage of actively practicing black physicians, from 2.1 percent in 1950 to 2.6 percent in 1980.

Dental Manpower

Unlike medicine, virtually all dentists practicing in the U.S. are U.S.-trained. While the number of black first-year students increased in absolute number and as a percentage of total enrollees, black dental students in the first-year as a percentage of total first-year enrollees actually declined at the end of the seventies. (See Table 38.) As a percentage of total enrollment (see Table 39) black enrollment reached a high of 4.8 percent in 1975-76 and then declined to 4.5 percent and remained at that level from 1977-78 to 1980-81. In 1980, 38.4 percent of the black dental school graduates in the U.S. graduated from Howard and Meharry. (See Table 37.) To achieve parity a substantial increase in black students would have to occur in the majority schools.

Pharmacy Manpower

Black enrollment in pharmacy has risen from 3.8 percent of the total in 1971-72 to 4.6 percent of the total in 1981-82 (see Table 25) and from 2.9 percent of the graduates in 1976-77 to 3.1 percent of the graduates in 1980-81. (See Table 40.)

There are 71 schools of pharmacy in the United States. The four minority schools, Florida A&M, Texas Southern, Xavier and Howard, graduated 50.1 percent of the black pharmacists with baccalaureate degrees from 1976-77 through 1980-81. In 1981 these schools graduated 47.9 percent of the total black pharmacy graduates. (See Tables 40 and 41.)

Appendix 2

Students and Faculty

Enrollment

Medicine

Total enrollment of all medical students in the United States rose by 75.9 percent during the thirteen-year period 1969-70 through 1981-82. (See Table 18.) During the same period black enrollment more than trebled. As a percentage of total enrollment, black enrollment rose from 2.8 percent of the total to 5.9 percent of the total. There was an accelerated period of growth until the 1974-75 academic year when black students constituted 6.3 percent of all enrollees. In 1981-82, after a six-year decline, the percentage of blacks increased again, but did not reach the previous peak. If first-year class and graduate data are analyzed, there is a higher rate of attrition among black students than white students. In 1974-75, 7.5 percent of entering students were black, yet in 1978-79, the year these students would normally graduate, only 5.2 percent of the graduates were black. By 1982 only 4.8 percent of the graduates were black. (See Tables 2 and 36.)

The distribution of enrollment between majority and minority students also shows an increase in the percentage of total enrollment in majority schools during the mid-seventies and then a decline as a percentage of the total. In 1970-71 the minority schools graduated 52.2 percent of the blacks. In 1969-70, 47.6 percent of total black enrollment was in the two minority schools, Howard and Meharry, and by 1976-77 it had dropped to 20.5 percent. The number of new medical schools and enrollment of students increased rapidly during this period. First-year enrollment of black students in minority schools reached a low of 17.6 percent of all first-year black students in 1974-75 and rose to 24.4 percent in 1978-79. In 1981-82 first year enrollment of black students in the minority schools was 23.7 percent of the total black first-year enrollment, but these schools accepted 24.1 percent of all new first-year black students, according to the Journal of the American Medical Association.74/ (See Table 1.) It should be noted that Morehouse School of Medicine began operations in 1978 and currently has approximately 32 students per class. Charles Drew began its M.D. program in 1981, in cooperation with the University of California System, with an enrollment of 24. The data for Charles Drew are included with the University of California at Los Angeles. If it were included with the minority schools, the percentage of students attending minority schools would increase. In 1982-83 Meharry Medical College decreased its first-year class size from 111 to 80 (in 1980 the freshman class was approximately 124.)

It is interesting to note the differences among majority medical schools in their success in recruiting and attracting black students. For example, in the southeastern part of the United States, there is a heavy concentration of black population and black undergraduate students. In 1979-80, although nationally 3.9 percent of graduates of majority medical schools were black, the Universities of Alabama, Emory, Louisiana State, Mississippi, Duke, Wake Forest, Eastern Virginia, Tennessee, Virginia, the Medical University of South Carolina and the Medical College of Georgia each had four percent or fewer black graduates in that year.75/ Yet at the University of North Carolina more than 11 percent of the graduates and more than 9 percent of the graduates at the University of Florida were black. Similar regional patterns exist in northern, midwestern and western states with large black populations. At the University of Illinois more than 8 percent of the graduates were black, yet only one school in the State University of New York System reached 5 percent and two of the private medical schools in New York City exceeded the national rate.

The number of white students in institutions of higher education has increased by 14.9 percent. The increase for blacks was over 200 percent. If the increase in medical school total enrollment (excluding blacks) is compared with the increase in the white higher education pool, the increase in total medical school enrollment (excluding blacks) increased at a much faster rate: a 14.9 percent increase in enrollment in higher education and a 70.3 percent increase in medical school total enrollment (excluding blacks).

The applicant to acceptance ratio has risen for black applicants and has fallen for non-minority applicants. (See Tables 19 and 20.) In 1973-74 there were 2.3 black applicants per acceptance and the rate has now risen to 2.5 applicants per acceptance. For non-minorities the direction is reversed. There were 2.9 applicants per acceptance in 1973-74. Today there are 2.1 applicants per acceptance. Almost 44 of every 100 black applicants were accepted in 1973-74; about 41 out of 100 were accepted in 1980-81. For non-minorities about 35 out of 100 were accepted in 1973-74 in contrast to 48 out of 100 in 1980-81. If the 1973-74 rate for blacks was in effect in 1980-81 there would be more than 84 additional black medical students or 7.9 percent more. Further, in August 1982 Dr. Leon Johnson, Jr., showed that while the non-minority applicant pool declined 16.5 percent between 1974-75 and 1981-82, the minority pool increased 11.6 percent.76/

In periodic surveys indicating freshmen's college interest in entering a profession, with 1974 as the most recent survey year, 3.6 percent of all freshmen aspired to study medicine and 4.1 percent of black freshmen indicated this field as an interest. (See Table 21.)

Dentistry

First-year and total enrollment of black dental students peaked numerically and as a percentage of the total in 1975-76, but started to rise again in 1980-81. (See Tables 38 and 39.) In 1980-81, 4.5 percent of all students enrolled in dental schools were black and 4.7 percent of first-year students were black. There is a high rate of attrition among black dental students: of the 290 who entered dental school in 1976-77, only 190 graduated. The attrition rate for whites in that year was 11.8 percent and for blacks it exceeded 30 percent. Of the black graduates, 38.4 percent came from the two minority schools, Meharry and Howard. (See Table 37.)

Dental enrollments are being reduced nationally; black enrollment, however, rose slightly between 1979-80 and 1980-81. Black dental students constitute a smaller percentage within their field than black medical students. The acceptance rates of blacks to dental schools are lower than white rates and higher than the black acceptance rate in medicine. For all groups, applicants per enrollee declined from 2.2 in 1977 to 1.6 in 1980. For blacks it increased from 2.1 to 2.2. Sixty-five percent of whites who applied in 1980 enrolled in contrast to 45.3 percent of blacks. (See Table 42.)

In the Southeast, an area with a large black population, a number of dental schools graduated black dentists at a rate below the national average of 3.7 percent. Such institutions include the Universities of Alabama, Emory, Louisville, Louisiana State, and Virginia Commonwealth. On the other hand, institutions like the University of California at Los Angeles, the University of California, San Francisco, the University of Maryland, and the University of Michigan substantially exceed the national average.

As in medicine, grade point averages and standardized test scores are lower for blacks than for whites. (See Table 43.)

Pharmacy

In 1981-82 blacks constituted 5.9 percent of total medical school enrollment and 4.6 percent of total enrollment in pharmacy. (See Tables 18 and 25.) In 1979-80, 5.1 percent of the graduates of schools of medicine were black while 3.5 percent of the graduates of schools of pharmacy were black. (See Tables 36 and 41.) In 1971-72, 57.1 percent of black pharmacy students were enrolled in minority schools. This total fell to 38.1 percent in 1981-82. (See Table 25.) A concentration of black pharmacy students also attends six or seven majority pharmacy institutions with the remaining black students scattered among the other sixty schools of pharmacy. (See Table 40.)

Faculty

The Association of American Medical Colleges has collected data for more than ten years on the "Participation of Women and Minorities on U.S. Medical School Faculties." Between 1971 and 1981 black faculty as a percentage of total faculty remained in a range of 1.6 percent to 1.8 percent. (See Table 44.) Black faculty increased by 43.4 percent numerically during this period from 565 to 810. However, total medical school faculty increased by 37.6 percent. In 1971, 64.1 percent of black faculty were in majority schools. By 1981 this percentage had risen to 74.1 percent. Black physicians represent 2.6 percent of the practicing physician pool, a higher proportion of total physicians than of faculty.

The colleges of veterinary medicine provided unpublished data for this study in a slightly different format than the data available for other fields, but with greater detail on faculty rank. Since affirmative action reached its peak in the mid-seventies and promotions within faculty ranks involve seniority considerations as well as merit, it is to be expected that fewer minority faculty would be at the higher ranks. The data show the largest proportion of blacks at the lecturer/instructor levels with a much lower and almost equal percentage at assistant, associate and full professor ranks. (See Table 29.) Of the black full professors of veterinary medicine, all but one were at Tuskegee. Less than half of the associate professors and slightly more than half of the assistant professors were at majority schools. Eighty percent of the instructors were at majority schools and the majority of the black lecturers were at Tuskegee.

Appendix 3

Student Financing

Almost 30 percent of black students participated in the Work Study Program as compared to less than 20 percent of the students in other racial categories. In addition, about 45 percent of black aid recipients in private schools participated in National Direct Student Loans in contrast to one-third of white and Hispanic students.77/

Dr. Johnson points out that by 1980-81, 15.7 percent of minorities in medical schools (in contrast to 3.1 percent of non-minorities) interrupted their medical education due to financial difficulties. In addition, 18.6 percent of minority graduates and 13 percent of non-minorities had indebtedness between $30,000-49,000 and 3.6 percent of minorities (contrasted to 1.4 percent of non-minorities) had indebtedness exceeding $50,000.78/

Dr. Johnson also shows a shifting between scholarships and loans. In 1980-81 the indebtedness of first-year minority students was $6,000. In 1981-82 it increased 30 percent to $8,242. The loan to scholarship ratio in the one-year period changed from 65/35 to 70/30.79/

Family Income Among Students

at Minority Health Professions Schools, Academic Year 1980-81

	Family Income Under $10,000	$10,000-$19,999	$20,000-$29,999	$30,000 +
School 1	30%	44%	19%	7%
School 2	52%	15%	12%	21%
School 3	38%	25%	15%	21%
School 4	30%	19%	18%	33%
School 5	31%	35%	30%	4%
School 6	78%	14%	6%	2%

One medical school provided data for two succeeding academic years, showing a decrease in students from all income levels below $30,000, with a marked decrease in students from families in the $20,000-29,999 category and a dramatic increase in students from families with incomes above $30,000.

Appendix 4

Minority Educational Institutions and Their Financing

Of the three minority medical schools, all are private schools. Meharry and Morehouse derive a much higher percentage of their revenues from tuition and fees than the average of all private medical schools. One of the two depends on tuition for one-fifth of its revenues. One of the two has contracts with a number of states and receives half of its funds from state appropriations and capitation payments. One receives slightly more state support than most private schools: 6% from state revenues. Charles Drew, receives more than half of its funding from state and local sources. The most dramatic difference between the minority and majority schools lies in revenues from biomedical research grants and contracts and patient care revenues. On average, all medical schools receive about one-fifth to one-quarter of their revenues from federal grants and contracts.

Almost no funds flow to the minority medical schools for biomedical research.

On average, medical schools receive about 9 percent of their revenues from hospitals and clinics and 15 percent from practice plans or about one-quarter of their revenues from patient care services. At Charles Drew faculty receive salaries from the county hospital for services in the hospital, but Meharry and Morehouse medical schools derive very little income from patient care services at this time. Most importantly, the diversity of sources of support is much less for minority schools than for majority schools, leaving the minority schools more severely affected by changes in any one form of financing.

Of the institutions included in the Association of Academic Health Centers' Impact Study 80/ only one institution received less than 25 percent of its revenues from federal grants and contracts and all six schools, both public and private, relied much less on state support and derived more revenues from patient care than the minority health professions schools.

The only dental school included in this study is Meharry. The sources of revenue of Meharry's dental school reveal the same patterns of disparity with the majority dental schools as do the minority medical schools with the majority medical schools.

In the minority schools of pharmacy, the state schools derived a higher percentage of their revenues from state appropriations than those in the AAHC sample. One of the three minority schools had a large biomedical research program; the other two received smaller proportions of their revenues from biomedical research than all four schools in the AAHC sample.81/ None of the minority schools derived income from hospitals and clinics while three of the four schools in the AAHC sample did. Financial distress grants accounted for almost 40 percent of one of the minority school's revenues.

At Tuskegee Institute's School of Veterinary Medicine tuition accounted for a larger share of revenues than the two schools in the AAHC sample. Research funding at Tuskegee fell midway between the two schools in the AAHC study but funding from the states was substantially lower at Tuskegee, even though one of the two schools in the AAHC sample was a private school.82/ Financial distress grants accounted for one-fifth of total revenues at Tuskegee. Hospital and clinic revenues at Tuskegee accounted for 3 percent of revenues as contrasted to over 14 percent in the two veterinary schools in the AAHC study.

TABLE 1

Black Enrollment in First-Year Classes
in U. S. Medical Schools
1969-70 through 1981-82*

Year	Total First-Yr. Enrollmt.	Black Enrollmt. All Schools	% of Total First-Yr. Enrollmt.	Blacks @ Majority Schools	% of Total First-Yr. Enrollmt.	% of Total Black Enrollmt.	Blacks @ Minority Schools	% Total First-Yr. Enrollmt.	% of Total Black Enrollmt.
1981-82	17,268	1,196	6.9	912	5.3	76.3	284	1.6	23.7
1980-81	17,186	1,128	6.6	--	--	--	--	--	--
1979-80	16,930	1,108	6.5	--	--	--	--	--	--
1978-79	16,501	1,061	6.4	802	4.9	75.6	259	1.6	24.4
1977-78	16,136	1,085	6.7	--	--	--	--	--	--
1976-77	15,613	1,040	6.7	836	5.4	80.4	204	1.3	19.6
1975-76	15,295	1,036	6.8	839	5.5	81.0	197	1.3	19.0
1974-75	14,763	1,106	7.5	911	6.2	82.4	195	1.3	17.6
1973-74	14,154	1,027	7.3	--	--	--	--	--	--
1972-73	13,677	957	7.0	761	6.1	79.5	196	1.4	20.5
1971-72	12,361	882	7.1	694	5.6	78.7	188	1.5	21.3
1970-71	11,348	697	6.1	527	4.6	75.6	170	1.5	24.4
1969-70	10,422	440	4.2	320	3.1	72.7	120	1.2	27.3

* Includes new entrants, and those repeating, re-entering or continuing first year.

Note: Data from Association of American Medical Colleges differ from the data reported in the Journal of the American Medical Association because AAMC data include new entrants and those repeating, re-entering or continuing their first year. JAMA shows different counts for total first-year and black first-year enrollment: 1981-82: total first-year 17,320, black first-year 973; 1980-81: total first-year 17,204, black first-year 932; 1979-80: total first year 17,014, black first-year 960. Similar differences in the data exist for all years.

Source: Medical School Admissions Requirements 1983-84, Association of American Medical Colleges, 33rd Edition (Washington, D.C.: Association of American Medical Colleges, 1982) and prior issues.

TABLE 2

Estimated Average Length of Life in Years by Race and Sex Selected Years 1950-1980

Year	White Male	Racial Minority Male	White Female	Racial Minority Female
1980*	70.5	65.3	78.1	74.0
1978**	70.2	65.0	77.8	73.6
1975**	69.4	63.6	77.2	72.3
1970**	68.0	61.3	75.6	69.4
1960	67.4	61.1	74.1	66.3
1950	66.5	59.1	72.2	62.9

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* Provisional data

** Excludes deaths of nonresidents of the United States

Source: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Health United States 1982 (Washington, D.C.: Government Printing Office, 1982)

TABLE 3

Live Births of Low Birthweight
as a Percent of Total Live Births:
Selected Years 1965-67 through 1979

	All Races Birthweight		White Birthweight		Black Birthweight		All Other Races Birthweight
Year	2,500 grams or less	1,500 gr. or less	2,500 gr. or less	1,500 gr. or less	2,500 gr. or less	1,500 gr. or less	2,500 gr. or less
1979	6.94	1.15	5.80	.90	12.55	2.37	--
1978	7.11	1.17	5.94	.91	12.85	2.43	--
1975	7.39	1.16	6.26	.92	13.09	2.37	--
1970	7.94	1.17	6.84	.95	13.86	2.40	--
1965-67*	8.3	--	7.2	--	--	--	13.7

* Data by birthweight for the black population are not available for these years.

Source: U.S. Department of Health and Human Services, Public Health Service
National Center for Health Statistics
Health United States 1981, Health United States 1982 (Washington, D.C.: Government Printing Office)

TABLE 4

Infant Mortality Rates by Race
United States: Selected Years 1950-1979

Year	Total Rate All Races	White Americans	Black Americans
1979	13.1	11.4	21.8
1978	13.8	12.0	23.1
1975	16.1	14.2	26.1
1970	20.0	17.8	32.7
1960	26.0	22.9	44.3
1950*	29.2	26.8	43.9

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*Excludes residents of Alaska and Hawaii

Note: Infant mortality rate is the number of deaths to infants under 1 year of age per 1,000 live births.

Source: U.S. Department of Health and Human Services, Public Health Service
National Center for Health Statistics:
Health United States 1981,
Health United States 1982,
(Washington, D.C.: Government Printing Office)

TABLE 5

Age-adjusted Death Rates
for Selected Causes of Death by Race:
United States, Selected Years 1950-79*

Cause of Death	1950		1960		1970		1979	
	White Male	Black Male	White Male	Black Male	White Male	Black Male	White Male	Black Male
All Causes	963.1	1,373.1	917.7	1,246.1	893.4	1,318.6	751.1	1090.4
Diseases of the heart	381.1	415.5	375.4	381.2	347.6	375.9	281.2	319.0
Cerebrovascular disease	87.0	146.2	80.3	141.2	68.8	124.2	43.8	79.8
Malignant Neoplasms	130.9	126.1	141.6	158.5	154.3	198.0	161.1	224.4
Respiratory System	21.6	16.9	34.6	36.6	49.9	60.8	57.8	78.8
Digestive System	54.0	59.4	47.5	60.4	41.9	58.9	40.7	61.5
Influenza and pneumonia	27.1	63.8	31.0	70.2	26.0	53.8	14.6	24.6
Tuberculosis	23.3	80.5	6.8	21.9	2.6	10.8	NA	NA
Cirrhosis of liver	11.6	8.8	14.4	14.8	18.8	33.1	15.7	29.9
Diabetes mellitus	11.3	11.5	11.6	16.2	12.7	21.2	9.5	17.3
All accidents	80.9	105.7	70.5	100.0	76.2	119.5	64.5	82.3
Motor vehicle accidents	35.9	39.8	34.0	38.2	40.1	50.1	36.2	34.2
Suicide	18.1	7.0	17.5	7.8	18.2	9.9	18.9	12.7
Homicide	3.9	51.1	3.9	44.9	7.3	82.1	10.1	71.3

* Deaths per 100,000 resident population.

Source: U.S. Department of Health and Human Services, Public Health Service,
National Center for Health Statistics,
Health United States, 1982, (Washington, D.C.: Government Printing Office, 1982)

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TABLE 5

Age-adjusted Death Rates
for Selected Causes of Death by Race:
United States, Selected Years 1950-79

Cause of Death	1950		1960		1970		1979	
	White Female	Black Female	White Female	Black Female	White Female	Black Female	White Female	Black Female
All Causes	645.0	1,106.7	555.0	916.9	501.7	814.4	412.2	636.1
Diseases of the heart	223.6	349.5	197.1	292.6	167.8	251.7	134.8	202.2
Cerebrovascular disease	79.7	155.6	68.7	139.5	56.2	107.9	36.8	64.7
Malignant Neoplasms	119.4	131.9	109.5	127.8	107.6	123.5	107.9	130.7
Respiratory system	4.6	4.1	5.1	5.5	10.1	10.9	17.3	18.1
Digestive system	41.1	40.2	33.9	37.5	28.1	34.1	26.2	37.0
Breast**	22.5	19.3	22.4	21.3	23.4	21.5	22.8	23.4
Influenza and pneumonia	18.9	50.4	19.0	43.9	15.0	29.2	8.0	11.4
Tuberculosis	10.2	51.2	2.2	9.2	.8	4.1	NA	NA
Cirrhosis of liver	5.8	5.7	6.6	8.9	8.7	17.8	7.1	13.6
Diabetes mellitus	16.4	22.7	13.7	27.3	12.8	30.9	8.6	21.9
All accidents	30.6	38.5	25.5	35.9	27.2	35.3	22.0	24.6
Motor vehicle accidents	10.6	10.3	11.1	10.0	14.4	13.8	12.6	8.9
Suicide	5.3	1.7	5.3	1.9	7.2	2.9	6.4	3.0
Homicide	1.4	11.7	1.5	11.8	2.2	15.0	3.0	14.3

** Females only.

Source: U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Health United States 1982. (Washington, D.C.: Government Printing Office, 1982)

TABLE 6

Assessment of Access to Health Care According to Access Indicators by Selected Demographic Groups

Access Indicators	Demographic Group							
	U.S. Population Percentage	Suburban Resident Percentage	Farm Resident Percentage	Low Income Percentage	High Income Percentage	Urban Blacks Percentage	Blacks in Rural South Percentage	Spanish S.W. Percentage
Regular Source of Care								
With	88	87	93	86	89	84	90	83
Without	12	13	7	14	11	16	10	17
Convenience								
Travel time to doctor								
less than 15 mins.	48	51	27	41	54	40	38	55
more than 15 mins.	52	49	73	59	46	60	62	45
Waiting time in office								
30 mins. or less	64	69	53	57	68	62	44	65
more than 30 mins.	36	31	47	43	32	38	56	35
Time spent with M.D.								
15 mins. or more	72	73	67	74	72	78	76	67
less than 15 mins.	28	27	33	26	28	22	24	33
Satisfaction								
Cost								
Satisfied	63	64	64	58	65	57	56	61
Dissatisfied	37	36	36	42	35	43	44	39
Waiting Time								
Satisfied	72	73	73	67	75	63	61	68
Dissatisfied	28	27	27	33	25	37	39	32
Utilization								
Seeing a Doctor								
Saw	76	78	68	73	79	77	65	65
Did not see	28	22	27	33	25	37	35	35
Seeing a dentist								
Saw	49	52	45	33	61	39	18	31
Did not see	51	48	55	67	39	61	82	69

Source: The Robert Wood Johnson Foundation "Special Report", Number One/1978 pp. 8-9 as reproduced in Health of Minorities and Women Chart Book, August 1982.

TABLE 7

Number and Percent of Persons Utilizing Specific Sources or Places of Outpatient Medical Care During Year Prior to Interview, by Selected Characteristics, 1978

	Number of Persons (000's)	Source or Place of Care						
		Private Doctor Office or Clinic	Hospital Outpatient Clinic	Hospital Emergency Room	Company or Industry Clinic	Neighborhood Health Center	Home	Other & Not Known
		% Utilizing						
Race								
White	185,052	83.7	4.8	3.0	.8	1.5	.3	5.8
Black	25,645	63.5	14.8	5.3	.8	1.4	.1	8.1
Family Income								
Less than $5,000	23,944	71.0	11.0	4.4	.2	5.7	.5	7.1
$ 5,000 - 9,000	36,081	76.5	9.0	3.9	.5	3.2	.4	6.6
$10,000 - 14,000	36,882	81.7	5.8	3.7	.7	1.9	.1	6.1
$15,000 or more	96,230	85.9	3.9	2.7	1.1	1.1	.3	5.0
Place of Residence								
SMSA	146,441	79.4	7.0	3.4	.9	2.6	.3	6.3
Central City	61,289	73.7	10.2	4.1	1.0	3.9	.4	6.8
Outside Central City	85,152	83.6	4.7	2.9	.9	1.6	.3	5.9
Outside SMSA	67,387	84.9	4.1	3.0	.5	1.6	.2	5.7
Nonfarm	61,028	84.3	4.3	3.2	.5	1.7	.3	5.8
Farm	6,360	90.3	2.2	1.7	.2	.9	--	4.6
All Persons	213,828	81.2	6.1	3.3	.8	2.3	.3	6.1

Source: U.S. Public Health Service, National Center for Health Statistics as printed in Health of Minorities and Women Chart Book American Public Health Association, 1982.

TABLE 8

Physician And Dentist Visits and Hospital Days and Episodes According to Income and Race/Ethnicity, Average Annual 1978-79

		Physician Visits		Dentist Visits		Hospital Episodes	
	Population (000's)	# Per Person Per Year	% of Persons with 1 or More Visit Yr. Prior to Interview	# Per Person Per Year	% of Persons with 1 Visit or More in Year Prior	# of Days Per Person Per Yr.	% of Persons with 1 Episode or More in Yr. Prior
All Incomes							
Total	214,776	4.7	75.4	1.6	50.0	1.1	10.4
White	172,760	4.8	75.9	1.8	53.4	1.1	10.5
Black	24,822	4.6	74.8	1.0	34.5	1.4	10.2
Less Than $10,000							
Total	56,940	5.5	76.0	1.2	36.3	1.7	13.1
White	39,290	5.7	76.8	1.2	38.4	1.8	13.8
Black	11,471	5.1	75.7	.9	31.5	1.8	11.7
$10,000 or More							
Total	137,326	4.5	75.8	1.9	56.4	.8	9.3
White	118,442	4.6	76.1	2.0	58.7	1.1	9.4
Black	9,874	4.1	75.9	1.3	39.9	.7	8.5

Source: U.S. Public Health Service, National Center for Health Statistics' Health Interview Survey as printed in Health of Minorities and Women Chart Book, American Public Health Association, 1982 p. 59.

TABLE 9

Number and Percent Distribution of
Persons Without a Regular Source of Medical Care by Main Reason,
According to Selected Characteristics, 1978

	Number of Persons w/out a Regular Source of Care (000's)	No doctor Needed	See different Doctors Depending on What is Wrong	Unable to Find the Right Doctor	Previous Doctor No Longer Available	Recently Moved	Other Reasons	Not Known
					Percentage			
Race								
White	26,175	50.0	16.3	4.8	7.2	13.1	6.3	2.3
Black	3,879	56.1	14.8	5.4	6.1	5.6	8.9	2.1
Family Income								
Less than $5,000	4,059	49.0	12.2	6.8	7.4	11.0	11.0	2.6
$ 5,000 - 9,999	5,885	52.5	11.8	5.6	6.1	14.1	7.5	2.4
$10,000 - 14,999	5,497	53.1	16.0	5.1	7.2	11.3	4.8	2.4
$15,000 or more	12,002	48.6	19.9	4.0	7.5	12.4	5.5	2.0
Place of Residence								
SMSA	23,233	51.2	16.5	4.4	6.7	11.5	6.9	2.4
Central City	9,804	54.1	14.6	5.5	6.2	9.2	7.8	2.5
Outside Central City	12,429	48.9	17.9	4.3	7.1	13.3	6.2	2.4
Outside SMSA	8,365	50.2	14.7	4.8	7.9	13.8	6.1	2.4
Nonfarm	7,763	49.7	14.7	4.9	7.7	14.4	6.3	2.4
Farm	602	56.3	15.1	3.2	11.8	5.8	4.3	3.5
All Persons	30,598	50.9	16.0	4.8	7.0	12.1	6.7	2.4

Source: U.S. Public Health Service, National Center for Health Statistics' Health Interview Survey as published in Health of Minorities and Women Chart Book American Public Health Association, 1982.

TABLE 10

Percentage of Physician Visits,
by Race of Patient and Specialty, 1978

Specialty	White	Black
General Practitioner	48.5	54.6
Dermatologist	1.7	1.5
Internist	10.5	5.5
Ob-Gyn	6.8	6.5
Ophthalmologist	2.5	1.5
Orthopedist	4.3	2.4
Otolaryn	2.3	1.3
Pediatrician	9.5	8.2
Psychiatrist	1.1	1.0
Radiologist	1.2	.6
Surgeon	3.0	2.7
Urologist	1.3	2.0
Other Specialists	3.2	5.3
Unknown	3.6	6.5

Source: NCHS 1978 Health Interview Survey as printed in Health Care in a Context of Civil Rights Institute of Medicine (Washington, D.C. National Academy Press 1981.)

TABLE 11

Number of Employed Black Practitioners in Selected Health Professions: 1950-1980 Selected Years

PHYSICIANS

Year	Total Physicians (MD and DO)	Rate per 10,000 Population	Black Physicians	% of Total Physicians	Rate per 10,000 Black Population
1980*	449,500	20.2	11,700	2.6%	4.2
1970	279,658	13.7	6,002	2.1%	2.6
1960	233,752	13.0	5,036	2.2%	2.7
1950	191,947	12.7	4,026	2.1%	2.7

* 1980 data on "Employed Practitioners" are not yet available from census books: 1980 data are "professionally active" individuals and may be higher relative to 1950-60-70 census data.

Notes:

1. In all cases, census numbers are lower estimates than data reported by other sources.
2. Resident population data from the U. S. Census were used to calculate "Rates per 10,000 population".

Source: U. S. Census data and Estimates and Projections of Black and Hispanic Personnel in Selected Health Professions 1980-2000 U.S. Department of Health and Human Services, H.R.A. 82-10 September 1982

TABLE 12

Number of Employed Black Practitioners in Selected Health Professions: 1950-1980 Selected Years

DENTISTS

Year	Total Dentists	Rate per 10,000 Population	Black Dentists	% of Total Dentists	Rate per 10,000 Black Population
1980*	126,200	5.64	3630	2.9%	1.37
1970	92,563	4.5	2363	2.6%	1.04
1960	86,887	4.8	2341	2.7%	1.24
1950	72,810**	4.8	1525**	2.1%	1.01

* 1980 data on "Employed Practitioners" are not yet available from census books: 1980 data are "professionally active" individuals and may be higher relative to 1950-60-70 census data.

** In 1950 estimates of dentists and pharmacists include only male practitioners.

Notes:

1. In all cases, census numbers are lower estimates than data reported by other sources.
2. Resident population data from the U. S. Census were used to calculate "Rates per 10,000 population ".

Source: U. S. Census data and Estimates and Projections of Black and Hispanic Personnel in Selected Health Professions 1980-2000, U.S. Department of Health and Human Services, H.R.A. 82-10 September 1982

TABLE 13

Number of Employed Black Practitioners
in Selected Health Professions:
1950-1980 Selected Years

PHARMACISTS

Year	Total Pharmacists	Rate per 10,000 Population	Black Pharmacists	% of Total Pharmacists	Rate per 10,000 Black Population
1980	144,200	6.37	3380	2.3%	1.28
1970	110,331	5.4	2782	2.5%	1.23
1960	92,233	5.1	1685	1.8%	.89
1950	80,855	5.3	1147	1.4%	.76

Notes:

In all cases, census numbers are lower estimates than data reported by other sources.

Resident population data from the U. S. Census were used to calculate "Rates per 10,000 population".

Source: U. S. Census data and Estimates and Projections of Black and Hispanic Personnel in Selected Health Professions 1980-2000, U.S. Department of Health and Human Services H.R.A. 82-10 September 1982

TABLE 14

Number of Employed Black Practitioners in Selected Health Professions: 1950-1980 Selected Years

VETERINARIANS

Year	Total Veterinarians	Rate per 10,000 Population	Black Veterinarians	% of Total Veterinarians	Rate per 10,000 Black Population
1980	34,355	1.52	533	1.6	.20
1970	19,176	.94	252	1.3	.11
1960	15,266*	.85	264*	1.7	.14
1950	11,460	.75	120	1.0	.08

* In 1960 estimates of veterinarians include only male practitioners.

Notes: In all cases, census numbers are lower estimates than data reported by other sources. Data on black veterinarians are gathered from a very small sample, and the estimating error may be large.

Resident population data from the U.S. Census were used to calculate "Rates per 10,000 population."

Source: U.S. Bureau of the Census. United States Census of Population. Occupational Characteristics

TABLE 15

Total Black Enrollment in U.S. Schools
of Veterinary Medicine 1971-72 through 1981-82

Year	Total Students	Total Minority Enrollmt.	Total Black Enrollmt.	% Total Enrollmt.	Blacks @ Majority Schools	% Black Enrollmt.	Blacks @ Minority School	% Black Enrollmt.	Tuskegee Total Enrollmt.
1981-82	8,447	406	179	2.1	42	23.5	137	76.5	224
1980-81	8,156	377	176	2.2	46	26.1	130	73.9	216
1979-80	7,803	313	NA	--	NA	--	NA	--	204
1978-79	7,334	302	NA	--	NA	--	NA	--	NA
1977-78	6,918	261	NA	--	NA	--	NA	--	NA
1976-77	6,243 *	239	139	2.2	NA	--	NA	--	171
1975-76	6,274	204	NA	--	NA	--	NA	--	169
1974-75	6,005	199	114	1.9	NA	--	NA	--	163
1973-74	5,763	175	115	2.0	NA	--	NA	--	NA
1972-73	5,439	143	105	1.9	NA	--	NA	--	136
1971-72	5,149	133	96	1.9	NA	--	NA	--	121

* U. Illinois did not provide breakdown by minority/non-minority of its total enrollment of 328 and is not included in the total.

Notes: Racial data werenot regularly collected until 1980-81; "Minority Enrollment" data were collected. According to the Association of American Veterinary Medical Colleges, schools do not want some data made public due to fear of comparisons. As a result, not much data are collected.

Sources: U.S. Department of Health and Human Services, Public Health Service, Health Resources Administration, Educational Statistics for Selected Health Occupations (Washington, D.C.: Government Printing Office, 1981), p. 43.

Health Minorities and Women Chart Book, American Public Health Association (Washington, D.C.: American Public Health Association, 1982), p. 110.

Also unpublished data from the Association of American Veterinary Medical Colleges.

TABLE 16

Freshman Enrollment of Veterinary Students

Year	White Enrollmt.	Minority Enrollmt.*	Minority Enrollmt. % of Total	Total Enrollmt.
1981-82	2,229	123	5.2	2,352
1980-81	1,944	110	5.3	2,054
1979-80	2,169	86	3.8	2,255
1978-79	1,990	96	4.6	2,086
1977-78	1,893	80	4.0	1,973
1976-77	1,793	69	3.7	1,862
1975-76	1,676	59	3.4	1,735
1974-75	1,607	56	3.4	1,663
1973-74	1,537	57	3.6	1,594

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* Minority includes American Indian, Hispanics, Blacks, etc. No further breakdown available. Excludes Canadian schools.

Source: Association of American Veterinarian Medical Colleges (AAVMC)

TABLE 17

Number of Full-Time Undergraduate Students in Institutions
of Higher Education by Racial/Ethnic Category
1968-69 through 1980-81 (Selected Years)

Academic Year	Total Students*	White Students**	% Total Students	Black Students	% Total Students	Hispanic Total Enroll.	% Total Students	Asians/ Pac.Isl.	% Total Students	Amer. Indians	% Total Students	Non-res. Aliens
1980-81	6,297,902	5,012,525	79.6	631,044	10.0	320,108	5.1	138,527	2.2	38,631	.6	157,067
1978-79	5,906,842	4,730,893	80.1	601,967	10.2	291,643	4.9	116,000	2.0	36,250	.6	130,089
1976-77	5,755,138	4,714,986	81.9	604,705	10.5	191,065	3.3	101,579	1.8	38,321	.7	104,487
1974-75	5,638,633	4,875,582	86.5	508,074	9.0	158,365	2.8	63,915	1.1	32,757	.6	NA
1972-73	5,543,204	4,857,819	87.6	464,734	8.4	130,840	2.4	57,577	1.0	32,234	.6	NA
1970-71	4,965,768	4,439,542	89.4	344,819	6.9	102,788	2.1	51,705	1.0	26,914	.5	NA
1968-69	4,819,819	4,364,008	90.5	287,053	6.0	90,879	1.9	48,386	1.0	29,493	.6	NA

* 1968-69 through 1974-75:
Total Students=48 states and District of Columbia.

1976-77 through 1980-81:
Alaska and Hawaii are added.

1978-79 and 1980-81:
Outlying areas (American Samoa, Canal Zone, Guam, Puerto Rico, Pacific Trust Territories and Virgin Islands) are added.

Categories exclude non-resident aliens in 1976-77, 1978-79 and 1980-81.

** In years 69-69 through 74-75 non-resident aliens are included in White Students' column.

Note: Data may be slightly understated. Survey of universities may be incomplete because those institutions receiving no federal funds did not always report data.

Source: U. S. DHEW, Office for Civil Rights.
Racial, Ethnic and Sex Enrollment Data from Institutions of Higher Education, Fall 1976.
also U. S. DHEW, National Center for Education Statistics.
Fall Enrollment in Higher Education, 1978.

} as reported in:
Minorities and Women in the Health Fields 1982 edition,
U.S. Department of Health and Human Services, p. 12.

TABLE 18

Total Black Enrollment
in U. S. Medical Schools
1969-70 through 1981-82

Year	Total Enrollmt.	Total Blk. Enrollmt.	% of Total Enrollmt.	Black TE @ Majority	% Total Enrollmt.	% Total Blk. Enroll.	Black TE @ Minority	% Total Enroll.	% Total Blk. Enroll.
1981-82	66,298	3,884	5.9	3,011	4.5	77.5	873	1.3	22.5
1980-81	65,189	3,708	5.7	--	--	--	--	--	--
1979-80	63,800	3,627	5.7	--	--	--	--	--	--
1978-79	62,213	3,537	5.7	2,761	4.4	78.1	776	1.2	21.9
1977-78	60,039	3,587	6.0	--	--	--	--	--	--
1976-77	57,765	3,517	6.1	2,797	4.8	79.5	720	1.2	20.5
1975-76	55,818	3,456	6.2	--	--	--	--	--	--
1974-75	53,554	3,355	6.3	2,660	5.0	79.3	695	1.3	20.7
1973-74	50,751	3,049	6.0	--	--	--	--	--	--
1972-73	47,366	2,582	5.5	1,953	4.1	75.6	629	1.3	24.4
1971-72	43,650	2,055	4.7	--	--	--	--	--	--
1970-71	40,238	1,509	3.8	--	--	--	--	--	--
1969-70	37,690	1,042	2.8	546	1.4	52.4	496	1.3	47.6

Note: Data from the Association of American Medical Colleges differ from data in the Journal of the American Medical Association because AAMC data include those repeating, re-entering or continuing their initial year. JAMA shows different counts for total enrollment and total black enrollment: 1981-82: T.E. 66,465, Black T.E. 3791; 1980-81: T.E. 65,497, Black T.E. 3719; 1979-80: T.E. 64,195, Black T.E. 3663. Similar differences in the data exist for all years.

Source: Association of American Medical Colleges:
Medical School Admissions Requirements 1983-84 and prior issues.

TABLE 19

Application and Acceptance Rates of Black Applicants
to First Year Classes in U. S. Medical Schools

First-Year Class	Total Applic.	Total # Accepted	Applic. Accept. Ratio	Black Applic.	% of All Applic.	Black Acceptees	% of All Acceptees	Black Applic. Accept. Ratio	Non-Minority Applic.	Non-Minority Accept.*	% of All Accept.	Applic. Accept. Ratio
1980-81	36,100	17,146	2.1	2,594	7.2	1,057	6.2	2.5	32,719	15,685	91.5	2.1
1979-80	36,141	16,886	2.1	2,599	7.2	1,024	6.1	2.5	32,761	15,349	90.1	2.1
1978-79	36,636	16,527	2.2	2,564	7.0	970	5.9	2.6	33,315	15,170	91.8	2.2
1977-78	40,569	15,977	2.5	2,487	6.1	966	6.0	2.6	37,270	14,648	91.7	2.5
1976-77	42,155	15,774	2.7	2,523	6.0	966	6.1	2.6	38,832	14,461	91.7	2.7
1975-76	42,303	15,365	2.8	2,288	5.4	945	6.2	2.4	39,254	14,057	91.5	2.8
1974-75	42,624	15,066	2.8	2,423	5.7	1,049	7.0	2.3	39,450	13,660	90.7	2.9
1973-74	40,506	14,335	2.8	2,227	5.5	977	6.8	2.3	37,457	13,012	90.8	2.9

* Non minority includes Whites, Asians/Pacific Islanders, Commonwealth Puerto Rican and other Hispanics and Foreign Students.

Applicants not specifying race were not included in the computation of percentages.

Note:
In 1980-81: 13,895 white Americans were first-year entrants.
In 1975-76: there were 34,868 white applicants,
12,985 white acceptees or 37.2% accepted.

Source: Medical School Admissions Requirements 1983-84
Association of American Medical Colleges
and prior issues.

TABLE 20

Percentage of Blacks and Non Minorities Accepted to First-Year Classes in U. S. Medical Schools

Year	% of Blacks Accepted	Year	% of Non Minorities Accepted
1980-81	40.7	1980-81	47.9
1979-80	39.4	1979-80	46.9
1978-79	37.8	1978-79	45.5
1977-78	38.8	1977-78	39.3
1976-77	38.3	1976-77	37.2
1975-76	41.3	1975-76	35.8
1974-75	43.3	1974-75	34.6
1973-74	43.9	1973-74	34.7

Source: Table 19

TABLE 21

Number and Percent of 1974, 1972, and 1966
Freshmen Aspiring to Become Health Professionals
by Race (Full-Time Students Only)

	Physicians		Dentists		Pharmacists		Veterinarians		Total Health Profess.		Total Freshman
Year	No.	%	No.	%	No.	%	No.	%	No.	%	Class
Total											
1974	59,708	3.6	21,075	1.3	15,845	.9	24,029	1.4	124,698	7.4	1,673,134
1972	62,092	4.0	18,085	1.2	13,168	.8	21,510	1.4	118,148	7.6	1,557,512
1966	48,933	4.2	18,533	1.6	9,548	.8	12,402	1.1	90,760	7.8	1,163,123
Blacks											
1974	5,101	4.1	955	.8	988	.8	537	.4	7,734	6.2	123,812
1972	4,224	3.1	1,011	.7	793	.6	338	.2	6,449	4.8	135,504
1966	2,521	4.3	547	.9	453	.8	241	.4	3,835	6.6	58,156
Nonblacks *											
1974	54,603	3.5	20,118	1.3	14,855	1.0	23,491	1.5	116,955	7.5	1,549,322
1972	57,865	4.1	17,073	1.2	12,375	.9	21,170	1.5	111,694	7.8	1,422,008
1966	46,410	4.2	17,986	1.6	9,094	.8	12,159	1.1	86,921	7.9	1,104,967

* Nonblack = White, Hispanic, Asian, Indian

Source: U.S. Department of Health, Education and Welfare, Health Resources Administration
Freshmen Interested in the Health Professions: A Summary Report, (Washington, D.C.: Government Printing Office) February 1977, p. 3.

TABLE 22

Medical Students Repeating the Academic Year: Selected Years 1974-75 through 1981-82

	1981-82		1980-81		1977-78		1974-75	
	Blacks	Other Students *	Blacks	Other Students *	Blacks	Other Students *	Blacks	Other Students **
First-Year Class								
Enrolled, Total	1,171	14,512	1,127	14,638	1,101	13,914	1,117	13,472
Repeating No. ***	198	324	195	288	142	225	161	162
% Repeating	16.9	2.2	17.3	2.0	12.9	1.6	14.4	1.2
All Other Classes								
Enrolled, Total	2,620	42,670	2,592	42,290	2,550	39,076	2,279	36,239
Repeating No.	159	295	149	313	161	286	136	229
% Repeating	6.1	.7	5.7	.7	6.3	.7	6.0	.6
% Promoted	--	--	--	--	--	--	85.6	98.9

* "Other students" does not include Hispanics, Indians, Puerto Ricans or Asians.
** "All other students" includes Asians, Pacific Islanders, Hispanics other than Mexican Americans and Puerto Ricans.
*** Ponce, South Dakota did not provide information.

Source: Journal of the American Medical Association
12/24-31/82
12/25/81
12/22-29/78
12/29/75

TABLE 23

Number and Percent of Black Physicians in Medical Internship and Residency Programs: Academic Years 1968-69 through 1980-81

Academic Year	Internships			Residencies		
	Total	Black	% Black of Total	Total	Black	% Black of Total
1980-81	- *	-	-	61,819	3,000	4.9
1979-80	-	-	-	64,615	2,944	4.6
1978-79	-	-	-	63,163	2,793	4.4
1977-78	-	-	-	56,019	1,628	2.9
1976-77	14,200	541	3.8	60,561	1,701	2.8
1975-76	NA	NA	-	NA	NA	-
1974-75	9,827	421	4.3	52,685	1,113	2.1
1973-74	11,031	334	3.0	49,082	1,032	2.1
1972-73	11,163	293	2.6	45,081	921	2.0
1971-72	12,066	272	2.3	42,512	827	1.9
1970-71	11,552	250	2.2	39,463	742	1.9
1969-70	10,808	192	1.8	37,139	706	1.9
1968-69	10,464	194	1.9	35,047	607	1.7

* The term "internship" is no longer used to designate graduate training programs.

Source: U.S. Department of Health and Human Services, Minorities and Women in the Health Fields, 1982 Edition, (Washington, D.C.: Government Printing Office, 1981)

TABLE 24

Number of Black Residents on Duty September 1 of Selected Years: 1968 through 1980

Specialty	September 1, 1980 Total Residents	Black Residents	% Total Residents	September 1, 1978 Total Residents	Black Residents	% Total Residents
Allergy and Immunology	192	4	2.1	120	4	3.3
Anesthesiology	2,490	97	3.9	2,378	65	2.7
Colon and rectal surgery	37	2	5.4	39	2	5.1
Dermatology	755	45	6.0	800	24	3.0
Dermatopathology	30	--	--	17	2	11.8
Family practice	6,344	280	4.4	6,000	317	5.3
Internal Medicine	15,964	752	4.7	16,178	631	3.9
Neurological surgery	511	39	7.6	560	32	5.7
Neurology	1,114	27	2.4	1,194	21	1.8
Nuclear Medicine	176	6	3.4	157	8	5.1
Obstetrics-gynecology	4,221	385	9.1	4,448	390	8.8
Ophthamology	1,480	48	3.2	1,561	66	4.2
Orthopedic surgery	2,418	94	3.9	2,482	88	3.5
Otolaryngology	933	38	4.1	951	44	4.6
Pathology	2,186	74	3.4	2,564	56	2.2
Blood Banking	23	1	4.3	17	--	--
Forensic Pathology	22	4	18.2	24	1	4.2
Neuropathology	52	4	7.7	39	2	5.1
Pediatrics	5,171	341	6.6	5,331	274	5.1
Pediatric allergy	2	--	--	56	3	5.4
Pediatric cardiology	130	2	1.5	117	3	2.6
Physical Medicine/Rehabilitation	492	13	2.6	436	7	1.6
Plastic surgery	367	11	3.0	406	10	2.5
Preventive Medicine						
General	157	11	7.0	166	6	3.6
Aerospace	25	1	4.0	16	1	6.3
Occupational	71	7	9.9	55	4	7.3
Public Health	31	5	16.1	26	1	3.8
Psychiatry	3,911	197	5.0	4,056	169	4.2
Child Psychiatry	426	12	2.8	552	19	3.4

(continued)

TABLE 24

Page 2 of 4

Number of Black Residents on Duty September 1 of Selected Years: 1968 through 1980

	September 1, 1980			September 1, 1978		
Specialty	Total Residents	Black Residents	% Total Residents	Total Residents	Black Residents	% Total Residents
Radiology, diagnostic	2,766	90	3.3	2,802	87	3.1
Radiology, diagnostic (nuclear)	48	2	4.2	56	1	1.8
Radiology, therapeutic	288	4	1.4	385	12	3.1
Surgery	7,794	333	4.3	7,792	385	4.9
Pediatric surgery	29	1	3.4	24	2	8.3
Thoracic surgery	256	10	3.9	294	13	4.4
Urology	917	60	6.5	1,064	43	4.0
TOTALS	61,819	3,000	4.9%	63,163	2,793	4.4%

TABLE 24

Number of Black Residents on Duty September 1 of Selected Years: 1968 through 1980

	September 1, 1972			September 1, 1970		
Specialty	Total Residents	Total Black Residents	% Total Residents	Total Residents	Total Black Residents	% Total Residents
Anesthesiology	1,954	50	2.6	1,681	29	1.7
Child Psychiatry	510	8	1.6	425	10	2.4
Diagnostic radiology	1,681	1	.1	352	--	--
Dermatology	650	15	2.3	599	20	3.3
Family Practice	1,041	16	1.5	265	7	2.6
General Practice	271	10	3.7	267	2	.7
General Surgery	6,840	127	1.9	6,539	108	1.7
Internal Medicine	8,297	156	1.9	7,194	150	2.1
Neurological surgery	609	14	2.3	578	13	2.2
Neurology	942	9	1.0	781	10	1.3
Obstetrics-gynecology	3,006	126	4.2	2,655	71	2.7
Ophthalmology	1,472	33	2.2	1,360	24	1.8
Orthopedic surgery	2,210	45	2.0	2,015	44	2.2
Pathology	2,560	36	1.4	2,335	48	2.1
Pediatrics	3,238	68	2.1	2,592	43	1.7
Pediatric allergy	111	6	5.4	95	6	6.3
Pediatric cardiology	147	7	4.8	119	1	.8
Physical Medicine & Rehabilitation	344	11	3.2	308	9	2.9
Plastic Surgery	312	2	.6	256	1	.4
Preventive Medicine	139	1	.7	103	1	1.0
Psychiatry	4,131	60	1.5	3,870	76	2.0
Radiology	1,806	55	3.0	2,604	29	1.1
Therapeutic Radiology	287	2	.7	98	1	1.0
Thoracic Surgery	285	12	4.2	271	9	3.3
Urology	1,078	18	1.7	1,011	14	1.4
Other Specialties	187	26	13.9	180	--	--
TOTALS	45,081	921	2.0	39,463	742	1.9

(continued)

TABLE 24 Page 4 of 4

Number of Black Residents on Duty September 1 of Selected Years: 1968 through 1980
September 1, 1968*

Specialty	Total Residents	Total Black Residents	% Total Residents
Anasthesiology	1,502	23	1.5
Child Psychiatry	473	3	.6
Dermatology	512	10	2.0
Family Practice	--	--	--
General Practice	402	13	3.2
General Surgery	6,064	116	1.9
Internal Medicine	6,163	111	1.8
Neurological surgery	504	6	1.2
Neurology	684	9	1.3
Obstetrics-gynecology	2,503	65	2.6
Preventive Medicine	104	--	--
Ophthalmology	1,238	16	1.3
Orthopedic surgery	1,573	26	1.7
Otolaryngology	873	8	.9
Pathology	2,230	36	1.6
Pediatrics	2,185	20	.9
Pediatric allergy	65	--	--
Pediatric cardiology	125	--	--
Physical Medicine & Rehabilitation	277	7	2.5
Plastic surgery	201	1	.5
Psychiatry	3,620	69	1.9
Radiology	2,240	20	.9
Therapeutic radiology	--	--	--
Thoracic surgery	279	6	2.2
Urology	867	9	1.0
Colon & Rectal surgery	29	--	--
Other Specialties (other than hospitals)	149	33	22.1
TOTAL RESIDENTS	35,047	607	1.7%

* "Data reported as of September 1, 1968 are incomplete, inasmuch as the replies from some hospitals indicated that legal considerations prevented the reporting of data". p.1547

Source: Journal of the American Medical Association,
Vol. 210 No.8, November 24, 1969.
November 22, 1971, November 19, 1973.
Vol. 246 No. 25, December 25, 1981.

TABLE 25

Total Enrollment in
U.S. Schools of Pharmacy by Race
Academic Years 1971-72 through 1981-82

Academic Year	Total Enrollmt *	White Americans	% of Total Enrollmt	Total Minority	% of Total Enrollmt	Black Americans	% of Total Enrollmt	Blacks @ Minority Colleges	% of Total Black Enrollmt	Blacks @ Majority Colleges	% of Total Black Enrollmt
1981-82	20,132	17,603	87.4	2,529	12.6	932	4.6	355	38.1	577	61.9
1980-81	21,628	19,102	88.3	2,526	11.7	945	4.4	368	38.9	577	61.1
1979-80	22,560	19,406	86.0	2,440	10.8	953	4.2	438	45.7	520	54.3
1978-79	23,078	20,108	87.1	2,263	9.8	942	4.1	457	48.5	485	51.5
1977-78	23,273	20,271	87.1	2,192	9.4	984	4.2	--	--	--	--
1976-77	23,465	20,544	87.6	2,089	8.9	938	4.0	--	--	--	--
1975-76	23,836	20,729	87.0	2,090	8.8	915	3.8	470	51.4	445	48.6
1974-75	22,688	19,885	87.6	1,727	7.6	727	3.2	377	51.9	350	48.1
1973-74	20,376	17,904	87.9	1,684	8.3	619	3.0	--	--	--	--
1972-73	17,909	15,784	88.1	1,662	9.3	659	3.7	--	--	--	--
1971-72	16,322	14,677	89.9	1,645	10.1	618	3.8	353	57.1	265	42.9

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* Excludes U. Puerto Rico

** The White American category includes all foreign students for each year except 1971-72. The numbers of foreign students are: 463 in 1972-73; 788 for 1973-74; 1,076 for 1974-75; 1,017 for 1975-76; 832 for 1976-77; 810 for 1977-78; 707 for 1978-79; 714 for 1979-80; 857 for 1980-81; 840 for 1981-82.

Source: Health of Minorities and Women Chart Book, American Public Health Association (Washington, D.C.: American Public Health Association, 1982), p. 114.

Enrollment Report on Professional Degree Programs in Pharmacy, Fall 1981, American Association of Colleges of Pharmacy, and prior issue.

TABLE 26

Applicants and Applications to U.S. Schools of Veterinary Medicine 1981 and 1982

	Number of Applicants to Vet. Med. Schools				Applications to Vet. Med. Schools				Applications to Majority Schools		Applications to Minority Schools	
	Total					1981 Mean Appl. Student		1982 Mean Appl. Student				
	1981	%	1982	%	1981		1982		1981	1932	1981	1982
White	5,787	90.8	5,820	94.1	7,374	1.27	7,746	1.33	7,147	7,559	227	187
Black	132	2.1	113	1.8	178	1.35	158	1.40	87	78	91	80
Hispanic	88	1.4	105	1.7	143	1.63	175	1.67	NA	NA	NA	NA
Native American	25	.4	27	.4	36	1.44	35	1.30	NA	NA	NA	NA
Asian	57	.9	63	1.1	81	1.42	87	1.38	NA	NA	NA	NA
Other	19	.3	54	.9	19	1.00	61	.70	NA	NA	41	40
Unknown	265	4.1			277	1.05			NA			
Total	6,373	100.0	6,182	100.0	8,108	--	8,262	--	NA	NA	359	307

Note: In 1980, 7286 applicants made 9525 applications to U.S. schools of veterinary medicine.

Source: Unpublished data from Association of American Veterinary Medical Colleges.

TABLE 27

Minority Faculty in Selected Departments 1978-1982
All Majority Schools:
Minority Schools not included

Basic Sciences	Year	Total Faculty	Total Minority Faculty	Black Faculty	% of Departmt. (Blacks)
Anatomy	1981	1,475	93	12	.8
	1978	1,440	96	13	.9
Biochemistry	1981	1,800	196	9	.5
	1978	1,655	170	13	.8
Microbiology	1981	1,349	114	14	1.0
	1978	1,269	99	10	.8
Pathology	1981	3,166	441	30	.9
	1978	2,952	396	23	.8
Pharmocology	1981	1,304	141	13	1.0
	1978	1,130	122	10	.9
Physiology	1981	1,579	124	7	.4
	1978	1,475	106	9	.6
Clinical Sciences					
Anesthesiology	1981	1,816	382	23	1.3
	1978	1,597	293	12	.8
Dermatology	1981	280	28	2	.7
	1978	314	23	5	1.6
Family Practice	1981	1,047	54	18	1.7
	1978	953	48	21	2.2
Internal Medicine	1981	9,245	863	92	1.0
	1978	8,523	740	78	.9
Neurology	1981	1,166	107	4	.3
	1978	1,041	99	11	1.1
Obstetrics-Gynecology	1981	1,572	153	48	3.1
	1978	1,612	202	32	2.0
Opthalmology	1981	674	56	5	.7
	1978	808	55	10	1.2
Orthopedic Surgery	1981	530	30	7	1.3
	1978	570	27	5	.9
Otolaryngology	1981	422	33	2	.5
	1978	512	35	2	.4
Pediatrics	1981	4,076	415	51	1.3
	1978	3,871	361	41	1.1
Physical Medicine	1981	534	83	8	1.5
	1978	575	62	7	1.2
Public Health	1981	1,177	85	31	2.6
	1979	1,220	89	33	2.7
Psychiatry	1981	4,383	386	102	2.3
	1978	5,150	320	104	2.0
Radiology	1981	2,945	385	34	1.2
	1978	2,675	310	29	1.1
Surgery	1981	3,864	315	43	1.1
	1978	4,087	297	46	1.1

Source: Association of American Medical Colleges.
Participation of Women and Minorities on U. S. Medical School Faculties

TABLE 28

Teaching Faculty in Schools of Dentistry
in the United States by Race:
Academic Years 1975-76 and 1980-81

	1975-76 Faculty	% of Total 75-76 Faculty	1980-81 Faculty	% of Total 80-81 Faculty
Total Faculty *	11,150	100.0	12,650	100.0
Total Minority Faculty	674	6.0	978	7.7
Black Faculty	297	2.7	398	3.1

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* Includes both full-time and part time faculty for basic science and clinical subjects

Source: American Dental Association as published in U.S. Department of Health and Human Services, Minorities and Women in the Health Fields, 1982 Edition.

TABLE 29
Faculty & Staff of
U.S. Veterinary Medical Colleges
Head Count Data -- Not FTE 1981-82

	Total # Faculty & Staff	# Minority Faculty & Staff	# Black Faculty & Staff All Schools	% Black of Total Faculty & Staff	Blacks @ Majority Schools	% Blacks @ Majority Schools	Blacks @ Minority School (Tuskegee)	% Black Minority School
Administrators	130	3	3	2.3	0	0	3	100.0
Professors	856	41	17	2.0	1	5.9	16	94.1
Associate Professors	580	39	11	1.9	5	45.5	6	54.5
Assistant Professors	709	45	15	2.1	8	53.3	7	46.7
Instructors	163	16	10	6.1	8	80.0	2	20.0
Lecturers	77	25	25	32.5	1	4.0	24	96.0
Assistants (Teaching & Research)	653	99	16	2.5	15	93.8	1	6.3
Clinical Interns	126	6	5	4.0	2	40.0	3	60.0
Clinical Residents	287	14	8	2.8	8	100.0	0	0
Total	3,579	288	110	3.1	48	43.6	62	56.4

Source: Unpublished data.
Association of American Veterinary Medical Colleges.

TABLE 30

Mean Financial Indebtedness of 1980 Dental School Graduates (excluding home mortgage) by Ethnic Category

Category	# of Responses*	Mean debt on entering Dent. Sch.	Mean debt from Dent. Schl. Exp.	Mean Total debt on Graduation
White	2,594	$ 1,460	$ 14,890	$ 17,930
Black (not Hispanic)	75	3,600	16,260	19,120
Hispanic (Black)	216	1,670	14,630	17,870
Hispanic (White)	115	1,570	17,490	22,010
American Indian (Alaskan)	17	1,370	19,240	25,710
Asian (Pacific Islander)	112	1,870	18,680	21,390

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* Number of "No" responses=99

Note: Blacks entered dental school with the highest mean indebtedness, but incurred the least amount of debt during their dental education.

Source: Journal of the American Dental Association, Vol. 102, June 1981, p. 837.

TABLE 31

Sources of Financial Support During Dental School for 1980 Dental School Graduates

Financial Source	Receiving Financial Support		Not Receiving Financial Support		No Response
	No.	%	No.	%	
Federal Health Professions Loan	1,138	35.3	1,959	60.7	131
National Direct Student Loan	933	28.9	2,153	66.7	142
Guaranteed Student Loan	2,066	64.0	1,068	33.1	94
Insured Student Loan	303	9.4	2,742	84.9	183
Personal Bank Loan	347	10.7	2,694	83.5	187
Loans from Other (Non-family)	542	16.8	1,524	78.2	162
Loans from Family	1,641	50.8	1,447	44.8	140
Public Health Service Scholarship	85	2.6	2,951	91.4	192
Armed Forces Scholarship	120	3.7	2,918	90.4	190
State Government Scholarship	334	10.3	2,714	84.1	180
Scholarships from Dental School	443	13.7	2,614	81.0	171
Scholarships from other Sources	251	7.8	2,792	86.5	185

Source: Journal of the American Dental Association,
Vol. 102 June 1981, p. 837.

TABLE 32

Sources of Loans and Scholarship Funds
for Medical Schools
1979-80 and 1980-81 (in 000's of dollars)

	1979-80			1980-81			1981-82		
Scholarship	$ Amt.	Number	% of Grand Total(79-80)	$ Amt.	Number	% of Grand Total(80-81)	$ Amt.	Number	% of Grand Total(81-82)
Armed Forces Health Professions	32,558	2,990	9.6	38,029	3,029	9.5	44,810	3,263	9.6
National Health Service Corps	49,815	4,401	14.7	50,111	4,079	12.5	38,721	2,882	8.3
National Medical Fellowship	673	587	.2	767	631	.2	912	766	.2
Exceptional Financial Need	3,551	340	1.1	5,135	441	1.3	4,900	418	1.1
School Funds	20,672	10,847	6.1	23,078	11,459	5.7	27,180	11,418	5.8
Other (with service commitment	8,409	1,638	2.5	11,108	2,628	2.8	10,960	2,196	2.4
Other scholarships (Administered by schools)	7,793	5,789	2.3	8,148	5,287	2.0	9,062	6,248	1.9
MSTP *	--	--	--	--	--	--	7,727	710	1.7
Total Scholarships	123,471	26,592	36.5%	136,376	27,950	34.0%	144,272	27,901	31.0%
Loans									
AMA-Education & Research Fund	1,606	708	.5	22	12	.1	--	--	--
Guaranteed Loans (bank or state loaned)	144,165	33,690	42.6	185,439	40,687	46.1	214,923	43,809	46.2
Health Education Assistance (HEAL)	4,289	546	1.3	15,302	2,121	3.8	33,166	4,701	7.1
Health Professions Loans	17,584	7,646	5.2	22,684	9,208	5.6	24,348	10,245	5.2
United Student Aid Loans	3,105	906	.9	1,465	361	.4	--	--	--
Guaranteed Loans (School-loaned	6,152	1,493	1.8	3,905	946	1.0	13,775	2,605	3.0
National Direct Student Loans	17,357	8,881	5.1	16,041	7,933	4.0	12,737	7,216	2.7
School Funds	8,520	5,699	2.5	9,290	5,952	2.3	9,625	6,283	2.1
Other Loans	10,397	3,959	3.1	9,947	3,536	2.5	9,096	3,678	2.0
ALAS/PLUS **							2,004	752	.4
Total Loans	213,175	63,598	63.1%	264,095	70,756	65.7%	319,674	79,289	68.7%
Work Study	1,400	1,038	.4%	1,441	1,206	.4%	1,483	1,274	.3%
Grand Total	338,046	91,228	100%	401,912	99,912	100%	465,429	108,464	100%

* MSTP = Medical Scientist Training Program (collected separately for first time in 1981-82).

** Auxiliary Loans to Assist Students or Parental Loans to Undergraduate Students.

Source: "82nd Annual Report on Medical Education in the U.S. 1981-82," Journal of the American Medical Association, December 24/31, 1982, p. 3269, December 25, 1981, p. 2922, and prior issues.

TABLE 33

Revenues of U.S. Medical Schools *
1978-79, 1979-80
and 1980-81 (in 000's of dollars)

Source	1978-79		1979-80		1980-81	
	Amount	Percent	Amount	Percent	Amount	Percent
State and Local Subsidies & Appropriations	1,050	21.4	1,191	20.9	1,342	20.9
Federal Grants and Contracts	1,189	24.2	1,368	24.0	1,472	22.9
Nonfederal Grants and Contracts	578	11.8	652	11.4	737	11.5
Medical Service Plans	727	14.8	880	15.4	1,001	15.6
Hospitals and Clinics	387	7.9	515	9.0	591	9.2
Tuition and Fees	265	5.4	308	5.4	346	5.4
Recovery of Indirect Costs on Grants and Contracts	269	5.5	320	5.6	444	6.9
Endowment Income and Gifts	85	1.7	95	1.7	103	1.6
General University Funds	96	2.0	111	1.9	104	1.6
Other Sources	260	5.3	261	4.6	285	4.4
Total Revenues	4,906	100.0	5,701	99.9	6,425	100.0

* Includes all medical schools except new and developing institutions and U. of Washington Medical School and Northwestern U. School of Medicine. Mayo Medical School data have not been included in totals.

Source: "82nd Annual Report on Medical Education in the United States 1981-82," Journal of the American Medical Association December 24/31, 1982 and prior issues.

TABLE 31

Revenues of Public and Private Medical Schools*
1978-79 to 1980-81 (in 000's of dollars)

Item	$ Amt.1978-79		% 1978-79		$ Amt.1979-80		% 1979-80		$ Amt.1980-81		% 1980-81	
	Public Schools	Private Schools	Public Schools	Private Schools	Public Schools	Private Schools	Public Schools	Private Schools	Public Schools	Private Schools	Public Schools	Private Schools
State & Local Subsidies & Appropriations	969	80	35.8	3.6	1,105	86	34.8	3.4	1,350	92	34.5	3.3
Federal Grants & Contracts	566	623	20.9	28.3	673	695	21.2	27.5	736	736	20.3	26.3
Nonfederal Grants & Contracts	246	332	9.1	15.1	276	376	8.7	14.9	314	423	8.7	15.1
Medical Service Plans	360	368	13.3	16.7	436	444	13.7	17.6	495	505	13.6	18.1
Hospitals & Clinics	203	183	7.5	8.3	247	268	7.8	10.6	308	383	8.5	10.1
Tuition & Fees	78	187	2.9	8.5	89	219	2.8	8.7	102	244	2.8	8.7
Recovery of Indirect Costs on Grants & Contracts	90	179	3.3	8.1	105	215	3.3	8.5	170	274	4.7	9.8
Endowment Income & Gifts	12	72	.4	3.3	17	77	.5	3.1	19	83	.5	3.0
General University Funds	73	23	2.7	1.0	84	27	2.6	1.1	82	22	2.3	.8
Other Sources	108	153	4.0	7.0	147	116	4.6	4.6	150	136	4.1	4.8
Total Revenues	2,705	2,220	99.9%	99.9%	3,178	2,523	100%	100%	3,628	2,797	100%	100%
Number of Medical Schools Reporting	66	46			73	46			73	46		

*Totals may not equal the sum of the parts due to rounding.

Source: "82nd Annual Report on Medical Education in the United States 1981-82," *Journal of the American Medical Association*, Vol. 248 No. 24 December 24/31, 1982.

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Total Black Enrollment in Medical Schools by Institution (1981-82)

Medical School	Total Enrollment*	Total Black Enrollment**	Black Enrollment as % of Total
Alabama	672	34	5.1
Alabama, South	266	9	3.4
Albany	517	7	1.4
Albert Einstein	732	17	2.3
Arizona	359	2	0.6
Arkansas	549	34	6.2
Baylor	663	18	2.7
Boston University	594	47	7.9
Bowman Gray	429	25	5.8
Brown	259	22	8.5
California, University of			
Davis	407	8	2.0
Irvine	398	23	5.8
Los Angeles (UCLA)	686	53	7.7
San Diego	510	24	4.7
San Francisco	648	15	2.3
California, Southern	587	20	3.4
Case Western Reserve	606	53	8.7
Chicago Medical	583	21	3.6
Chicago Pritzker	431	10	2.3
Cincinnati	766	57	7.4
Colorado	500	7	1.4
Columbia	600	24	4.0
Connecticut	345	11	3.2
Cornell	439	33	7.5
Creighton	450	9	2.0
Dartmouth	226	13	5.8
Duke	490	32	6.5
East Carolina	172	17	9.9
Emory	464	25	5.4
Florida	461	43	9.3
Florida, South	289	8	2.8
Georgetown	827	39	4.7
George Washington	618	28	4.5
Georgia	729	34	4.7
Hahnemann	730	50	6.8
Harvard	670	62	9.3
Hawaii	284	1	0.4
Howard	504	407	80.8
Illinois	1377	84	6.1
Illinois, Southern	216	19	8.8
Indiana	1227	34	2.8

TABLE 35

Total Black Enrollment
in Medical Schools by Institution
(1981-82)

Medical School	Total Enrollment*	Total Black Enrollment**	Black Enrollment as % of Total
Iowa	705	24	3.4
Jefferson	887	27	3.1
Johns Hopkins	479	42	8.8
Kansas	788	6	0.8
Kentucky	437	10	2.3
Loma Linda	568	11	1.9
Louisiana State			
New Orleans	725	25	3.4
Shreveport	403	15	3.7
Louisville	570	18	3.2
Loyola-Stritch	464	7	1.5
Marshall	133	1	0.8
Maryland	710	38	5.4
Massachusetts	419	13	3.1
Mayo	162	7	4.3
Meharry	484	411	84.9
Miami	642	12	1.9
Michigan State	440	48	10.9
Michigan, University of	953	74	7.8
Minnesota			
Duluth	97	0	0.0
Minneapolis	1056	22	2.1
Mississippi	603	30	5.0
Missouri			
Columbia	453	14	3.1
Kansas City	357	20	5.6
Morehouse	81	55	67.9
Mount Sinai	459	25	5.4
Nebraska	618	12	1.9
Nevada	188	0	0.0
New Jersey: UMD			
New Jersey Medical	698	93	13.3
Rutgers	452	47	10.4
New Mexico	295	3	1.0
New York Medical	759	14.	1.8
New York University	713	23	3.2
New York: SUNY			
Buffalo	560	38	6.8
Downstate	894	53	5.9
Stony Brook	292	19	6.4
Upstate	604	24	4.0

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Total Black Enrollment
in Medical Schools by Institution
(1981-82)

Medical School	Total Enrollment	Total Enrollment	Black Enrollment as % of Total
North Carolina	636	84	13.2
North Dakota	224	0	0.0
Northwestern	708	24	3.4
Ohio, Medical College of (Toledo)	451	22	4.9
Ohio, Northeastern	289	6	2.1
Ohio State	851	46	5.4
Oklahoma	708	11	1.6
Oral Roberts	134	4	3.0
Oregon	463	0	0.0
Pennsylvania, Medical College of	460	16	3.5
Pennsylvania State (Hershey)	390	12	3.1
Pennsylvania, University of	677	43	6.4
Pittsburgh	543	36	6.6
Rochester	391	8	2.0
Rush	517	27	5.2
Saint Louis	611	16	2.6
South Carolina Medical University of	638	16	2.5
South Carolina, Univ. of	163	2	1.2
South Dakota	230	0	0.0
Stanford	397	37	9.3
Temple	732	77	10.5
Tennessee State, East	146	6	4.1
Tennessee, University of	797	11	1.4
Texas A & M	125	1	0.8
Texas Tech	336	6	1.8
Texas, University of			
Dallas (Southwestern)	817	34	4.2
Galveston	801	21	2.6
Houston	758	17	2.2
San Antonio	798	14	1.8
Tufts	605	59	9.8
Tulane	609	42	6.9
Uniformed Services Univ.	518	21	4.1
Utah	405	3	0.7
Vanderbilt	418	18	4.3
Vermont	368	0	0.0

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Total Black Enrollment in Medical Schools by Institution (1981-82)

Medical School	Total Enrollment *	Total Black Enrollment **	Black Enrollment as % of Total
Virginia, Eastern	297	19	6.4
Virginia, Med.Col.of	670	33	4.9
Virginia, University of	550	15	2.7
Washington University (St. Louis)	530	45	8.5
Washington, University of	728	6	0.8
Wayne State	1,008	79	7.8
West Virginia	343	2	0.6
Wisconsin, Medical College of	815	43	5.3
Wisconsin, University of	653	25	3.8
Wright State	373	36	9.7
Yale	431	41	9.5
Total	65,545	3,883	5.9

Note: Association of American Medical Colleges data and Journal of the American Medical Association data differ by 92 black students on total enrollment data.
This table excludes Puerto Rican medical schools.

* Source: Journal of the American Medical Association "82nd Annual Report on Medical Education in the U. S. 1981-1982".
Vol. 248 No. 24 p. 3305 December 24/31, 1982.
Vol. 248 No. 24 p. 3305 December 24/31, 1982.

** Source: Association of American Medical Colleges "Medical School Admission Requirements" 1983-84. 33rd edition

TABLE 36

Graduates of Schools of Medicine
in the United States by Race:
Academic Years 1968-69 through 1981-82

Academic Year	Total Graduates	Black Graduates	% of Total Graduates	Black Grads of Majority Schools	% of Total Graduates	% of Total Black Graduates	Black Grads of Minority Schools	% of Total Graduates	% of Total Black Grads
1981-82	15,985*	763**	4.8	--	--	--	--	--	--
1980-81	15,667*	773**	4.9	--	--	--	--	--	--
1979-80	15,135	768	5.1	590	3.9	76.8	178	1.2	23.2
1978-79	14,966	774	5.2	--	--	--	--	--	--
1977-78	14,393	793	5.5	--	--	--	--	--	--
1976-77	13,607	752	5.5	--	--	--	--	--	--
1975-76	13,561	743	5.5	--	--	--	--	--	--
1974-75	12,714	638	5.0	--	--	--	--	--	--
1973-74	11,613	511	4.4	--	--	--	--	--	--
1972-73	10,391	341	3.3	216	2.1	63.3	125	1.2	36.7
1971-72	9,551	229	2.4	98	1.0	42.8	131	1.4	57.2
1970-71	8,974	180	2.0	62	.7	34.4	118	1.3	65.6
1969-70	8,367	165	2.0	--	--	--	--	--	--
1968-69	8,059	142	1.8	48	.6	33.8	94	1.2	66.2

* Includes all students
** Includes only U.S. citizens.

Note: "...the number of Negroes receiving the MD degree during the 1955-1964 decade remained virtually constant at about 166 per year." Journal of the American Medical Association, November 25, 1968 p. 1992.

Source: U.S. Department of Health and Human Services, Public Health Service, Health Resources Administration, Minorities and Women in the Healt ields, 1982 Edition (Washington, D.C.: Government Printing Office, 1981), p. 19.

"Medical Education in the United States," Journal of the American Medical Association, November 19, 1973, p. 914.

"Medical Education in the United States," Journal of the American Medical Association, November 22, 1971, p. 1221.

TABLE 37

Graduates of Schools of Dentistry
in the U.S. 1970-71 through 1979-80

Year	Total Graduates *	White Americans (derived) **	% of Total Graduates	Black Graduates	% of Total Grads	Black Grads of Majority Schools	% of Total Black Grads	Black Grads of Minority Schools	% of Total Black Grads
1979-80	5,193	4,671	90.0	190	3.7	117	61.6	73	38.4
1978-79	5,368	4,883	91.0	182	3.4	--	--	--	--
1977-78	5,279	4,785	90.6	203	3.8	--	--	--	--
1976-77	5,141	4,680	91.0	215	4.2	--	--	--	--
1975-76	5,278	4,811	91.2	213	4.0	--	--	--	--
1974-75	4,933	4,565	92.5	187	3.8	--	--	--	--
1973-74	4,479	4,144	92.5	154	3.4	--	--	--	--
1972-73	4,191	3,950	94.2	110	2.6	--	--	--	--
1971-72	3,929	3,762	95.7	74	1.9	--	--	--	--
1970-71	3,743	3,605	96.3	53	1.4	--	--	--	--

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* Excludes University of Puerto Rico graduates.

** Derived: Total graduates--minority graduates=white graduates (may include foreign graduates).

Source: U.S. Department of Health and Human Services, Public Health Service, Health Resources Administration, Minorities and Women in the Health Fields, 1982 Edition (Washington, D.C.: Government Printing Office, 1981) p. 31.

TABLE 38

First-Year Enrollment in Schools of Dentistry in the U.S. 1971-72 through 1980-81

Year	Total First-Yr. Enrollmt. *	White Enrollmt.	% of Total First-Yr. Enrollmt.	Black First-Yr. Enrollmt.	% of Total First-Yr. Enrollmt.
1980-81	5,964	5,192	87.1	283	4.7
1979-80	6,066	5,321	87.7	274	4.5
1978-79	6,235	5,554	89.1	280	4.5
1977-78	5,890	5,249	89.1	296	5.0
1976-77	5,869	5,224	89.0	290	4.9
1975-76	5,697	5,060	88.8	298	5.2
1974-75	5,555	5,004	90.1	279	5.0
1973-74	5,389	4,860	90.2	273	5.1
1972-73	5,287	4,812	91.0	266	5.0
1971-72	4,705	4,293	91.2	245	5.2

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* Excludes University of Puerto Rico

Source: U.S. Department of Health and Human Services, Public Health Service, Health Resources Administration, Minorities and Women in the Health Fields, 1982 Edition (Washington, D.C.: Government Printing Office, 1981), Table 19.

TABLE 39

Total Enrollment in Schools of Dentistry in the United States 1971-72 through 1980-81

Year	Total Enrollmt.*	White Enrollmt.	% of Total Enrollmt.	Black Enrollmt.	% of Total Enrollmt.
1980-81	22,581	19,947	88.3	1,022	4.5
1979-80	22,225	19,772	89.0	1,009	4.5
1978-79	21,930	19,665	89.7	977	4.5
1977-78	21,277	19,117	89.8	968	4.5
1976-77	20,790	18,692	89.9	955	4.6
1975-76	20,549	18,529	90.2	977	4.8
1974-75	19,945	18,122	90.9	945	4.7
1973-74	19,187	17,531	91.4	872	4.5
1972-73	18,209	16,838	92.5	765	4.2
1971-72	17,153	16,072	93.7	597	3.5

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* Excludes U. Puerto Rico

Source: Health of Minorities and Women Chart Book,
American Public Health
Association, August 1982.

TABLE 40

Majority and Minority Schools Producing
American Black Pharmacists (B.S. and B.P. Degrees)
Academic Years 1976-77 through 1980-81*

Year	Total Pharm. Produced (71 Schools)	Total Black Pharm. Produced	% of Total Pharm. Produced	Minority Schools (4)	% of Total Black Pharm. Produced	% of Total Pharm. Produced	Majority Schools (67 Colleges)	% of Total Black Pharm. Produced	6 Top Maj. Schools in Prod. of Black Pharm.	% of Total Black Pharm. Produced	% of Black Pharm. Prod. by Maj. Schools
1980-81	6,908	215	3.1	103	47.9	1.5	112	52.1	36	16.7	32.1
1979-80	6,905	238	3.4	115	48.3	1.7	123	5.1	52	21.8	42.3
1978-79	7,095	258	3.6	140	54.3	2.0	118	45.7	52	20.2	44.1
1977-78	7,430	225	3.0	105	46.7	1.4	120	53.3	42	18.7	35.0
1976-77	7,649	218	2.9	115	52.8	1.5	103	47.2	44	20.2	42.7

* Does not include Pharm.D. students.

Source: American Journal of Pharmacy Education
Vol. 45, 291-298 (1981)
Vol. 43, 45-52 (1979)
Vol. 43, 420-426 (1979)
Vol. 41, 499-505 (1977)

TABLE 41

Graduates of Schools of Pharmacy in the United States by Race: Academic Years 1971-72 through 1979-80(a)(b)

Academic Year	Total Graduates	Total Minority Grads.	% of Total Grads.	Black Grads.	% of Total Grads.
1979-80	7,091 *	622	8.8	247	3.5
1978-79	7,383	689	9.3	272	3.7
1977-78	7,613	646	8.5	233	3.1
1976-77	7,803	589	7.5	226	2.9
1975-76	7,611	724	9.5	205	2.7
1974-75	6,559	508	7.7	176	2.7
1973-74	5,788	472	8.2	144	2.5
1972-73	5,070	496	9.8	142	2.8
1971-72	4,802	353	7.4	138	2.9

(a) Excludes Puerto Rico
(b) Data for 1972-73 and subsequent years include only recipients of their first degree in pharmacy, whether baccalaureate or doctorate.

* Does not include 40 graduates of Oregon State nor 125 graduates of University of Southern California in 1980.

Source: U.S. Department of Health and Human Services, Minorities and Women in the Health Fields. p. 39: from "Degrees Conferred by Schools and Colleges of Pharmacy" American Journal of Pharmacy Education

TABLE 42

Number and Percent Distribution
of Dental School Applicants and Enrollees (AADS)
by Ethnic Group: 1977 - 1980 Entering Classes

Year	White Appl.	White Enrollees	% Enrolled	Appl. Per Enrollee	Black Appl.	Black Enrollees	% Enrolled	Per Enrollee	Percent Distribution			
									White Appl.	Black Appl.	White Enrollees	Black Enrollees
1980 Entering Class	7,251	4,712	65.0	1.5	550	249	45.3	2.2	82.5	6.3	86.0	4.5
Total: All Groups	9,601	5,999	62.5	1.6	--	*Min. = 120 *Maj. = 129	--	--	--	--	--	--
1979 Entering Class	6,774	4,102	60.5	1.6	484	206	42.6	2.3	79.4	5.7	82.5	4.1
Total: All Groups	8,532	4,973	58.3	1.7	--	--	--	--	--	--	--	--
1978 Entering Class	8,221	4,542	55.2	1.8	507	220	43.4	2.3	84.8	5.2	87.5	4.2
Total: All Groups	9,690	5,195	53.6	1.9	--	--	--	--	--	--	--	--
1977 Entering Class**	10,654	5,030	47.2	2.1	558	266	47.7	2.1	83.0	4.4	86.3	4.6
Total: All Groups	12,835	5,826	45.4	2.2	--	--	--	--	--	--	--	--

* In the 1980 entering class there were 120 blacks enrolled at minority schools of dentistry and 129 blacks enrolled at predominantly white schools of dentistry.

** U. of California, San Fransisco did not provide data.
Partial data for U. Kentucky.

Note:

Data may be slightly understated because not all schools belong to AADS Application Service. However, non-member schools' data are collected from other services and are presented in the reports.

Source: American Association of Dental Schools.
Applicant Analysis: 1980 Entering Class
and prior issues.

TABLE 43

GPA and DAT Averages of Accepted Dental School Applicants by Ethnic Identification*: 1977

	Overall GPA (S.D.)+		Science GPA (S.D.)+		Academic DAT (S.D.)+		PMAT (S.D.)+	
Black	2.83	(.43)	2.68	(.52)	3.1	(1.0)	3.2	(1.5)
White	3.27	(.36)	3.21	(.41)	5.0	(1.0)	5.3	(1.4)
Indian	3.08	(.29)	2.99	(.34	4.6	(1.6)	5.0	(1.6)
Asian	3.38	(.35)	3.34	(.39)	5.3	(1.1)	5.8	(1.5)
Hispanic	3.11	(.41)	3.02	(.48)	3.8	(1.4)	4.4	(1.7)

* Number with grade point averages: 5183 (overall), 5030 (science)
Number with DAT scores: 5614

+ Standard Deviation

Note: Data may be slightly understated because not all schools belong to the AADS Application Service. However, non-member schools' data are collected from other sources and are presented in the Applicant Analyses.

Source: American Association of Dental Schools
Applicant Analysis: 1977 Entering Class

TABLE 44

Distribution of U. S. Medical School Faculty by Race: Selected Years 1971-72 through 1981-82

Year	Total Faculty +	White Faculty	% of Total Faculty	Black Faculty	% of Total Faculty	Black Faculty @ Majority Sch.	% of Total Black Faculty	Black Faculty @ Minority Sch. ‡	% of Tot.Blk. Faculty
1981	47,701 *	39,232	82.2	810	1.7	600	74.1	210	25.9
1978	47,140 **	38,641	82.0	820	1.7	554	67.6	266	32.4
1975	40,682	33,345	82.0	733	1.8	468	63.8	265	36.2
1971	34,658 ***	27,005	77.9	565	1.6	362	64.1	203	35.9

+ Total faculty figure includes those faculty of unknown race, approximately 8% in each year.

‡ Minority schools=Howard, Meharry, Ponce and University of Puerto Rico.

* Data (1971, 1975 and 1978) include all part-time and full-time salaried faculty, including University of Puerto Rico. Data for 1981 do NOT include part-time faculty.

** Full-time only=41,161 faculty.

*** Includes 12.5% of unknown race (4,328 faculty).

Source: Association of American Medical Colleges data
Participation of Women and Minorities on U.S. Medical School Faculties;
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Dr. SATCHER. Thank you. Although blacks represent 11.7 percent of the U.S. population, only 2.6 percent of the Nation's physicians are black; 2.9 percent of the dentists, 2.3 percent of the pharmacists; and 1.6 percent of veterinarians.

While there may be an emerging overall surplus of health manpower in the Nation, there continues to be an acute shortage of black health professionals.

This study also illustrates in many ways how the inequity of minorities in health professions reflects upon other areas of minority livelihood, especially health, economic status, and stability. Clearly, with the results of this startling study, we feel it is important that many programs authorized by the Health Personnel and Manpower Act be strengthened and priority given to institutions who train minorities in the health professions and to students who attend these institutions.

For your consideration of the reauthorization of the Health Personnel and Manpower Act, I will first reflect the American Academy of Family Physicians' request, then move on to the Association of Minority Health Professions Schools' response to your committee's preliminary reauthorization proposal, and outline our association's proposals to strengthen minority participation in the health professions.

The American Academy of Family Physicians believes that Federal support for family practice training programs remains critical to their stability and continuation. Therefore, the American Academy of Family Physicians requests that the committee reauthorize grants for academic administrative units for clinical instruction in family medicine at the current level of $11 million, and that the committee reauthorize grants to support residency programs in family practice at a modest increase above the current level of $36 million. We believe that this is a critical time in the history of these programs and their development, and that it would in fact be a grave error to cut back at this time.

The Association of Minority Health Professions Schools, in working with the committee staff in recent months, has become knowledgeable of your preliminary plans to reauthorize the programs under the Health Personnel Act at levels consistent with program appropriation levels for fiscal year 1984. Indeed, we would like to express that this reflects a significant improvement over the administration's current proposals to eliminate these programs, and we commend you.

In addition, we would like to believe that we can continue to work with you and your staff to further improve upon the Federal initiative that your proposals represent, so that it will reflect an even stronger commitment to the training of minorities in the health professions.

With this in mind, as well as the results of the study we have referred to in my testimony, I would like to present to the committee the legislative proposals that the association has developed in response to the current critical national shortage of minorities in health professions, as part of the record.

The CHAIRMAN. We would be happy to put that in the record, without objection.

[The following was received for the record:]

February 22, 1984

AMHPS

THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS
400 First Street, N. W., Suite 712
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HEALTH PERSONNEL LEGISLATIVE PROPOSALS OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

STUDENT FINANCIAL AID

A. Health Professions Guaranteed Student Loan type program with units of $10,000 per annum, $50,000 total maximum. This is to be separate from the undergraduate guaranteed student loan program.

Authorization Level

FY '85 - $5.0 million

FY '86 - $5.2 million

FY '87 - $5.5 million

B. Targeting of health profession student loans as far as new capital is concerned, to institutions with a minimum of 20% minority* enrollment and to students who are from families where the income is less than $25,000 a year. The health professions student loan program would also be targeted to institutions that were developing in the sense that they were less than 15 years old. (Please see Attachment A for details.)

Authorization Level

FY '85 - $10 million

FY '86 - $11 million

FY '87 - $13 million

C. A program that would provide incentive scholarships and loans to students who are committed to practicing in underserved communities. These students would be funded at the undergraduate level but not after finishing health professions school. The understanding would be that if in fact they practice in underserved communities, they would be forgiven. It is a loan forgiveness concept. They would be completely forgiven the debt. Where they fail to practice, there would be a payback system, and that has been described by Dr. Adams. (Please see Attachment B for details.)

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*For purposes of these proposals, the term minority refers to the definition of minority as it is defined by the Health Resources and Services Administration of the Department of Health and Human Services.

Authorization Level

FY '85 - $25 million

FY '86 - $40 million

FY '87 - $55 million

MAINTENANCE GRANT FOR MINORITY INSTITUTIONS

These grants would go to institutions with 20% or more minority student enrollment and would consist of $5,000 per minority student enrolled and $5,000 per minority student graduate. The rationale behind this proposal is that institutions committed to the education of a significant percentage of minority students incur certain burdens and costs associated with that commitment. The institutions must meet the costs of education which cannot be fully met by the limited tuition that can be paid by minority students. In addition, there is the need to develop special programs to insure survival of minority students with academically deficient backgrounds. This would also serve as an incentive to all health professions schools to increase their minority enrollment. This is particularly important in the face of the dilemma of a projected surplus of other health professionals over the next five or ten years and severe shortage of minority health professionals that has been documented by the recent study by the Association of Minority Health Professions Schools.

Authorization Level

FY '85 - $12.5 million

FY '86 - $12.5 million

FY '87 - $13.5 million

ENDOWMENT DEVELOPMENT GRANTS FOR HEALTH PROFESSIONS SCHOOLS WITH 50% OR MORE MINORITY OR LOW INCOME STUDENTS

Grants will be matching in nature and designed to encourage private sector endowment funds. The rationale for this proposal is based on the fact that the fiscal strength of minority health professions schools has been severely compromised because of their commitment to disadvantaged students, disadvantaged patients and disadvantaged communities. Many of the graduates of minority health professions schools are first generation college graduates and in some cases first generation high school graduates. Very few of them come from families which have the kind of wealth which would allow for major gifts to these institutions. Likewise many of these institutions have lost substantial funds in the process of providing care to indigent patients for many years without reimbursement. Such endowment grants would provide a level of stability which would allow minority health professions schools to continue to contribute significantly to the education of minority health professionals and others. Endowment funds from the Federal Government would be matched 50-50 by funds raised by the institutions from non-Federal sources. The goal of this grant would be to elevate the institutions endowment to a level that would allow them to derive 10% of their unrestricted operating budgets from the income from endowment funds.

Authorization Level

FY - '85 - $4.0 million

FY - '86 - $4.4 million

FY - '87 - $4.7 million

MINORITY FACULTY DEVELOPMENT GRANTS

These grants would be geared toward the identification, recruitment and training of minorities for careers as teachers and investigators on the faculties of health professions schools. It is also intended that minority institutions faculty be strengthened by this initiative. The rationale for this proposal is based on the severe shortage of minority faculty in health professions schools. Today that figure is less than 2%. It is also felt that the shortage of minority faculty impacts negatively upon the recruitment, retention and graduation of minority students at health professions schools. This grant would aid institutions in identifying minorities for careers as teachers and investigators and would provide funding for a limited period of time to assist with start up for research projects, and other areas of professional development, for these individuals at select institutions. A minimum of 25% of these funds to support these programs would be earmarked for minority institutions. Collaboration between minority health professions schools and majority health professions schools with established research reputations would be encouraged. Stipends and/or compensation, and other academic support for the individuals involved would also be part of the grant to these institutions. Individual institutions shall be allowed not more than 10% of these funds; the Secretary has the authority to waive this provision, if deemed necessary.

Authorization Level

FY '85 - $3.0 million

FY '86 - $4.0 million

FY '87 - $4.5 million

ADVANCED FINANCIAL DISTRESS GRANT PROGRAM

Currently, three institutions (Meharry Medical College, Tuskegee School of Veterinary Medicine, and Xavier School of Pharmacy) are operating under a five year plan to achieve financial self-sufficiency. They are beginning the third year of that plan with no further authorization beyond FY 1984. We propose that the Financial Distress Grant Program be reauthorized through FY 1988 rather than through FY 1986, as planned. This proposed extension of the Financial Distress Grant program is necessitated by several factors beyond the control of the three institutions involved. First, associated with a repressed economy all three institutions have suffered a decrease in endownment income, a failure to significantly increase state and other non-federal support, a decrease in federal grants and contracts, and a failure to increase SREB and other contract students. In addition, changes in reimbursement policies for clinical care have hampered a projected increase in funding from this source. These changes have all taken place in the face of an increase in institutional costs. Two of the institutions (Meharry Medical College and Xavier School of Pharmacy) have exprienced changes in top administration within the last two years making it difficult to adhere to the five year plan. In spite of these problems, all three institutions are making significant progress toward financial self-sufficiency (as documented by recent HRSA site visits), but more time is needed to adjust to complicated and unforeseen variables.

We are, therefore, requesting that the Financial Distress Grant program be continued at the current level of $5.6 million through FY 1986 and then phased out through FY 1988.

Authorization Level

FY '85 - $5.6 million

FY '86 - $5.6 million

FY '87 - $4.0 million

ATTACHMENT A

A HEALTH PROFESSIONS STUDENT LOAN PROGRAM FOR INSTITUTIONS WHICH SERVE SIGNIFICANT NUMBERS OF MINORITY AND ECONOMICALLY DISADVANTAGED STUDENTS

A. Objectives

to help insure access to health professions education for low income and minority students

to encourage health professions schools to maintain substantial commitment to enrolling, retaining and graduating disadvantaged students

to provide an affordable non-service obligated loan program targeted to institutions with demonstrated accomplishments consistent with the present national objective

B. Rationale

History has demonstrated that the original Health Professions Student Loan Program (HPSL) was effective in helping the nation achieve the objective of increasing the numbers of physicians and other health professionals. The record of the last 20 years will also show that a limited number of health professions schools have been successful in enrolling and retaining underrepresented minority students at levels of twenty (20) percent of total enrollment. The schools which have made such commitments require proportionately more funds to meet the financial assistance needs of their students.

The proposed modified Health Professions Loan Program is intended to acknowledge the requirement of certain schools for more student financial assistance funds while recognizing the effectiveness of the HPSL approach in achieving national objectives. It is also intended to provide equity for health professions schools which have been established so recently that they do not have significant HPSL funds outstanding which might be recycled in new loans as is planned for more established schools.

C. Program Provisions

1. Authority

The Health Professions Student Loan Program authority is extended and revised. The secretary shall make grants to schools of MODVOPP for the purpose of maintaining a low interest loan fund for needy students.

2. Eligibility

Schools which are elibible for capital grants shall meet one of the following three conditions:

a) shall have at least 35 percent of its enrollment made up of students whose gross family income is $30,000 or less.

b) shall have at least 12 percent of its enrollment made up of students who are minorities which are underrpresented in the health professions

c) shall have offered the professional degree for 15 years or less, and have at least 20 percent of its enrollment made up of students from families with gross income of $25,000 or less, or shall have at least 12 percent of its enrollment made up of students who are from minority groups which are underrepresented in the health professions.

3. Matching Requirement

Schools which are eligible for capital contributions are required to provide 1/9 of the capital funds while 8/9 is provided by the federal government.

4. Student Eligibility

Students who borrow from this program must have a demonstrated need of at least one-half of the established costs.

5. Cost of Loans (interest rates)

Borrowers shall be charged nine (9.0) percent interest per annum. No interest is charged during training. Repayment commences 90 days after end of training and must be completed within 10 years.

6. Authorization for Appropriation

$10	million	FY 85
11	"	FY 86
13	"	FY 87
16	"	FY 88

ATTACHMENT B

LOW INCOME STUDENT, SERVICE OBLIGATED, LOAN PROGRAM (LISSOL) FOR HEALTH PROFESSIONS STUDENTS

A. Objectives

- to insure access to health professions education for low income individuals

to promote the expansion and maintenance of minority student enrollment in health professions schools

to promote a continuing supply of health care providers to shortge areas.

B. Rationale

There is considerable evidence to support the further development of a national policy of increasing the numbers of minority and economically disadvantaged persons who are graduated from health professions schools. The most compelling evidence is Department of Health and Human Services data which show that the health status of the nation's minorities is below the norm for the nation as a whole. At the same time several studies of medical graduates of Meharry Medical College and Howard University, show that minority graduates tend to serve minority patient populations to a greater extent than non-minority health professionals.

Finally, it is well established that minority students require proportionately more financial assistance to enter and complete health professions study than do non-minority students. Thus, it is reasonable to conclude that any national policy which has the production of health professionals who come from minority populations and economically disadvantaged groups as an objective, would require a program of student financial assistance to be implemented effectively. The critical question then becomes: what means should be taken to provide the needed financial assistance?

A Low Income Student, Service Obligated, Loan Program addresses several issues and concerns. First, it responds to the widespread public sentiment for students to be responsible for financing their own education when their education is to prepare them for high income professions. Second, the question of students' perception of debt burden as deterrant to health professions study is addressed. Third, the creation of incentives for borrowers to choose service in shortage areas is accomplished. And fourth, the maintenance of specialty choice freedom and practice location options is achieved.

C. Program Provisions

"Loans For Low Income Students"

1. The secretary shall make grants to a public or non-profit school of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine, or public health which is properly accredited, for loans to be awarded by the school to eligible full-time students.

2. Eligibility: Students are determined to be eligible to borrow funds through this program when they (1) have been accepted by the school for full-time enrollment, and (2) are U.S. citizens or permanent residents, and (3) have a demonstrated financial need for $6,000 or one-half the cost of education at the school, whichever is greater.

3. Loan Limits: Eligible students may borrow up to $15,000 per year for a total of $75,000 over a five-year period. The borrowed amount shall not exceed the demonstrated need.

4. Cost of Loans (interest rates): No interest is charged during the in-school period. Borrowers shall be charged interest on their loans in accordance with the following schedule: 33 percent of the extant prime interest rate for funds borrowed in the first year of study, 50 percent of prime for funds borrowed in the second year of study, 75 percent of the prime for funds borrowed in the third year of study, and 100 percent of prime for funds borrowed in the fourth and subsequent years of study.

5. Repayment Requirements:

a) During a postgraduate training period, interest only is due and payable beginning ninety (90) days following the start of the postgraduate training, except the secretary may waive interest payments for health professionals in training programs in designated manpower shortage specialties. Interest payments during the postgraduate training period shall be made in accordance with the following schedule:

during first postgraduate year, pay interest only on loans obtained for year one of professional degree education.

during second postgraduate year pay interest only on loans obtained for years one and two of professional degree education.

during third postgraduate year pay interest only on loans obtained for year three and prior years of professional degree education.

during postgraduate year, four and subsequent years full interest on LISSOL loans will be due and payable.

b) When professional training ends, principal and interest payments are due and payable beginning one hundred eighty (180) days following the end of formal education or training. The secretary shall authorize the forgiveness of loans for borrowers who practice in designated shortage areas in accordance with the following schedule: Twenty-five (25) percent of the outstanding balance at the beginning of each year the borrower serves in a designated underserved area, up to a total of seven years; one hundred (100) percent of the outstanding balance in the eighth year of service in a designated shortage area. The repayment period may not exceed 20 years plus six months following the end of formal professional training.

6. Service obligation: Borrowers in this program are expected to provide two years of service in a designated shortage area immediately upon completion of formal training. Those who elect not to provide such service shall be assessed a penalty of $15,000 or twenty (20) percent of the outstanding balance at the beginning of the third year after completion of training, if the expected service has not commenced. One half of the assessed penalty will be due and payable within six months of notification. The remainder will be added to the principal balance. The secretary may approve requests for guarantee of commercial loan to program borrowers, who need funds to set up practice in designated shortage areas. The secretary may also waive the penalty if no shortage areas have been designated for the profession for which the borrower holds the professional degree.

7. In recognition of great shortages of minority faculty and the need for such faculty, the secretary can designate academic institutions as underserved areas with regards to forgiveness for loans under the low income service obligated loan program. A year of academic appointment at an academic institution so designated by the secretary would be considered the same as a year of practice in an underserved area.

8. Authorization of appropriation: for the purpose of making federal capital contributions into the student loan funds of schools which have established such funds under the authority of this title, there are authorized to be appropriated $50,000,000 for the fiscal year ending September 30, 1985; $80,000,000 for the fiscal year ending September 30, 1986; $110,000,000 for the fiscal year ending September 30, 1987; and $120,000,000 for the fiscal year ending September 30, 1988. For the fiscal year ending September 30, 1989 and the two subsequent fiscal years, there are authorized to be appropriated to the secretary such sums as may be necessary to enable students who have received a loan under this program for any academic year ending before October 1, 1988, to continue or complete their education.

Dr. **Satcher**. These proposals would serve to strengthen minority student financial aid, institutional base and participation, as well as strengthen and develop minority faculty recruitment and training.

We believe the implementation of these proposals would serve as a national commitment to provide for the eventual equitable participation of minorities in the health professions, and would pave the way for a degree of institutional self-sufficiency that is highly desired by the members of our association.

We have asked that the advanced financial distress grant be continued through 1987 and we would like to make it very clear that our goal is to get out of the distress grant business and to become self-sufficient, and we are moving rapidly in that direction.

Our legislative proposals are attached for your consideration. We look forward to working with you on these and other proposals under your consideration.

Mr Chairman, we thank you and we would be happy to respond to any questions.

[The prepared statement of Dr. Satcher and responses to questions submitted by Senator Hatch follow:]

AMHPS

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TESTIMONY OF

DAVID SATCHER, M.D., Ph.D.
PRESIDENT OF

THE
MEHARRY MEDICAL COLLEGE

ON BEHALF OF

THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

AND

THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

CONCERNING

REAUTHORIZATION OF THE HEALTH PERSONNEL

AND

MANPOWER TRAINING ACT

PRESENTED ON

MARCH 14, 1984

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Association of Minority Health Professions Schools regarding Reauthorization of the Health Personnel and Manpower Training Act. I am also pleased to present in part, some key observations and views of the American Academy of Family Physicians.

The member institutions of the Association, The Morehouse School of Medicine, Tuskegee Institute School of Veterinary Medicine, Xavier University of Louisiana, Florida A & M University College of Pharmacy, Texas Southern University School of Pharmacy, Charles R. Drew Postgraduate Medical School, and the Meharry Medical and Dental Colleges, all have a vital interest in the programs authorized by this Act. The eight institutions represented by our Association have graduated 43 percent of the Nations' Black Physicians and Dentists, 50 percent of the Nations' Black Pharmacists, and 90 percent of the Nations' Black Veterinarians. Many programs contained in this Act profoundly affect the educational missions and success of our institutions, and our collective and individual goals to increase the number of Black and other Minority Health Professionals in the Nation. The institutions represented by the Association, as well as our students rely heavily upon this Federal support.

Mr. Chairman,please allow me to thank you and your dedicated staff for the interest and commitment you have displayed to us recently regarding minorities in the health professions.

Presidents Budget Proposal for Health Professions

The Presidents Budget proposals for Fiscal year 1985 requests Congress to eliminate and/or make significant cuts in Health Professions programs vital to the survival and maintenance of the progress being made by minority institutions and minority students. In fact, the Presidents Budget for Health Professions for FY 1985 proposes cuts of $85 million from the current FY 1984 program levels. Of these cuts, several reach deep into the financial base that is necessary for many minority students to continue their education. Funds for Health Professions Student Loans, Exceptional Financial Need Scholarships, and National Health Service Corp Scholarships that many former EFN recipients receive to continue medical education, have been proposed for elimination. The Association of Minority Health Professions Schools does not believe this adequately reflects, by any means, the Administrations current alleged committment to accelerate efforts to strengthen Minorities in the Health Professions.

I would also like to add that the American Academy of Family Physicians looks upon the Presidents Budget proposals for family medicine units and residency programs under this Act as being far short of the necessary amounts to continue a reasonable level of support.

Comprehensive Study Finds Severe Shortages of Minorities in the Health Professions

On June 16th, 1983 at a press conference in the U.S. Capitol, a comprehensive study was announced, funded by the Robert Wood Johnson Foundation, "Blacks and the Health Professions in the 80's: A National Crisis and a Time for Action". This study documents the severe shortage of Black Physicians, Dentists, Veterinarians and Pharmacists in the United States. I am pleased to submit copies of this Study to the Committee, which contains abundant data to support the conclusions cited.

Although Blacks represent 11.7 percent of the U.S. population, only 2.6 percent of the nations physicians are Black; 2.9 percent of the dentists; 2.3 percent of the pharmacists; and 1.6 percent of the veterinarians are Black. While there may be an emerging overall surplus of health manpower in the nation, there continues to be an acute shortage of Black Health Professionals. This study also illustrates in many ways how the inequity of minorities in the health professions reflects upon other areas of minority livelihood, such as health and economic status and stability. Clearly, with the results of this startling study, we feel it is important that many programs authorized by the Health Personnel and Manpower Act be strengthened and give priority to institutions who train minorities in the health professions, and to students who attend these institutions.

Congressional Reauthorization of Health Professions Initiatives

For your consideration of the Reauthorization of The Health Personnel Act, I will first reflect the American Academy of Family Physicians request, then move on to the Association of Minority Health Profession Schools response to your Committees preliminary Reauthorization proposal, and outline our Associations proposals to strengthen Minority participation in the Health Professions.

The American Academy of Family Physicians believes that federal suppport for Family practice training programs remains critical to their stability and continuation. Therefore, the American Academy of Family Physicians requests that the Committee reauthorize grants for Academic Administrative Units for Clinical Instruction in Family Medicine at the current level of $11 million, and that the Committee reauthorize grants to support residency programs in family practice at a modest increase above the current level of $36 million.

The Association of Minority Health Professions Schools, in working with the Committee staff in recent months, has become knowledgeable of your preliminary plans to reauthorize the programs under the Health Personnel Act at levels consistent with program appropriation levels for Fiscal Year 1984. Indeed, we would like to express that this reflects a significant improvement over the Administrations' current proposals to eliminate these programs, and we commend you. In addition, we would like to believe that we can continue to work with you and your staff to further improve upon the federal initiative that your proposals represent, so that it will reflect an even stronger commitment to the training of Minorities in the Health Professions.

With this in mind, as well as the results of the Study I have referred to in my testimony, I would like to present to the Committee, the legislative proposals that the Association has developed in response to the current critical National shortage of minorities in the health professions. These proposals would serve to strenghten minority student financial aide, institutional base and participation, as well as strengthen and develop minority faculty recruitment and training. We believe the implementation of these proposals would serve as a national commitment to provide for the eventual equitable participation of minorities in the health professions and would pave the way for a degree of institutional self-sufficiency that is highly desired by the Members of our Association.

Our Legislative Proposals are attached for your consideration. We look forward to working with you on these, and other proposals under your consideration.

Mr. Chairman, Thank you. I would be happy to respond to any questions you have.

RESPONSE TO QUESTIONS
FOR PANEL III

TESTIMONY ON BEHALF
OF THE
ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

1. The proposals that we have submitted as legislative initiatives are directly related to the study completed by the Association of Minority Health Professions Schools (AMHPS). This study indicated, among other things, a persistent shortage of black and other minority health professionals in this country. In light of the study's findings, our proposals specifically target minority health professional students and institutions educating a large proportion / of these students. It was not our intent to be punitive to schools which are trying to reach out to minorities, but which still have student bodies with less than 20 percent minority student enrollment. It was our evaluation of the current status of minority students however, that the larger the percentage of minority and low income students enrolled at an institution, the greater the need for financial aid. Many institutions with a very small enrollment of minority and low income students are in a relatively better position to fund financial aid to students who have need.

Of the proposals which we have submitted for student financial aid, it is our position that the proposal to target health professional student loans to institutions with a minimum of 20 percent minority students would have the greatest positive impact on the affected students and would be most appropriate method of dealing with the problems which we have cited.

2. The Health Careers Opportunities Program (HCOP) has indeed been very effective in increasing the quality and quantity of the applicant pool of minority students. In the long run, it is this program which will have the greatest impact upon the persistent shortage of minority health professionals. A follow-up study on undergraduate college or high school students who have participated in the HCOP Program at Meharry revealed that between 60 and 80 percent of those students successfully matriculated at a health professional school. This is an impressive finding since less than 40 percent of all black and other minority students applying to medical schools are, in fact, admitted. Therefore, we feel that the HCOP Program has in fact, had a major impact and has a potential to have an even greater impact.

DS:bs

cc: AMHPS Members

The CHAIRMAN. Thank you so much. Dr. Nelson, we will turn to you at this point.

Dr. NELSON. Thank you, Mr. Chairman. I am Alan R. Nelson, I am an internist practicing in Salt Lake City, and I am on the AMA board of trustees, and with me is Harry N. Peterson from the AMA's Division of Legislative Activities.

Mr. Chairman, the AMA believes that the medical education system in this country is second to none and is a fundamental component in assuring needed health care services to the American people. Federal support for medical education and research has been an important factor in achieving this level of recognition.

With the rapid rise in the number of physicians in recent years, it can be concluded that the Federal stimulus to further increase the capacity to train new physicians is unnecessary.

In our view, moreover, decisions in this area should be dictated, to the greatest extent possible, by market forces, through the application of Government involvement only when appropriate.

It is within the context of increased use of market forces and local resources to make the basic decisions regarding physician manpower—with the Federal Government offering assistance when necessary to assure that other important goals are met—that we offer our comments today.

The CHAIRMAN. Alan, if you will forgive me, I am going to have to run to the floor; it's just one of those vicissitudes that we have to go through.

I am going to ask Dr. Sundwall, whom you know very well, to finish up the hearing and ask the questions that I would like to have asked here today, and button down some of the problems that we have.

So I just want to extend my apologies to each of you for having to leave early, but I just don't have much choice in the matter.

So just continue if you will.

[Dr. Sundwall assumes the Chair.]

Dr. NELSON. The AMA encourages continued limited support by the Federal Government for medical schools. We believe that Federal assistance can be a valuable adjunct to other resources in three major areas: assistance for reconstruction and rehabilitation of outdated facilities; special project assistance; and assistance for institutions in extreme financial distress.

Some medical school basic science and research facilities are outdated and in various states of disrepair. In some cases, the facilities can pose safety hazards or are not physically adequate to be used for new equipment or laboratories. With the explosion of new technology and instrumentation, it is critical that medical schools expose their students to the medical state of the art. With inadequate or antiquated facilities, this is not always possible.

Therefore, we support continued Federal assistance for rehabilitation and renovation of medical school facilities.

Another area where Federal support can provide necessary assistance is the support of special projects within medical schools. And we believe that this should continue.

While the AMA generally supports the utilization of local resources and market forces to determine the fiscal viability of medical schools, there are certain situations where we believe that direct general financial assistance is appropriate to allow an institution to achieve financial stability.

Therefore, we support financial distress grants, for a limited period of time, for those institutions that have unique attributes or resources, until they return to fiscal solvency.

Mr. Chairman, medical education today is very expensive and the costs that an individual can incur in the process can be overwhelming. Specifically, medical school tuition in some DC area medical schools is now estimated at approximately $19,000 a year; Colorado out-of-State tuition is $26,000 a year.

The AMA is concerned that medical education costs could, without assistance, place the medical profession out of the reach of all but the rich. And such an outcome must be avoided.

Therefore, we continue to support a broad array of financial assistance to capable students who choose a career in medicine. We believe that in the light of the earning potential of a physician that, to the greatest extent possible, Federal assistance should be directed toward loans and loan guarantees.

We therefore support reauthorization of an adequate funding for the health professions student loan program, the health education assistance loan program, and, while not within the jurisdiction of this committee, we would encourage all members of the committee to support continued adequate funding for the guaranteed student loan program.

In addition, we believe that in the case of especially needy individuals, it is appropriate to continue the exceptional financial need grant program.

As noted in our comments concerning the National Health Service Corps, we do not believe that it is necessary or appropriate to provide for new scholarships for the purpose of obligating service. Such a system is an extremely expensive way to meet manpower needs in select areas and involves extremely long lead times.

Where there may be future manpower requirements for shortage areas, we would suggest that emphasis be placed on the use of loan forgiveness rather than on scholarship programs for the National Health Service Corps.

In conclusion, we are proud of the role the AMA has played in establishing a medical education system that is a benchmark for other systems. Through our participation in the voluntary accreditation of medical schools, quality of medical education has remained a principal focus. The Federal Government has also played a major role in this success and should be commended. We support continued Federal involvement in medical education as an appropriate adjunct to the market to assure the continued availability of medical care that the citizens of the United States have come to expect and deserve.

The AMA supports major portions of the legislation currently before the committee. We urge the committee to carefully consider our views and make such changes as necessary, to reflect these views.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Nelson and responses to questions submitted by Senator Hatch follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Labor and Human Resources
United States Senate

Presented by

Alan R. Nelson, M.D.

RE: Reauthorization of the Medical Education
Programs

and

S. 2301 - Health Services, Preventive Health Services, and Home
Community-Based Services Act of 1984;
S. 2303 - Alcohol and Drug Abuse and Mental Health Service Block
Grant Amendments of 1984;
S. 2308 - Primary Care Block Grant Amendments of 1984;
S. 2311 - Health Maintenance Organization Amendments of 1984; and
S. 2281 - National Health Service Corps Amendments of 1984

March 14, 1984

Mr. Chairman and Members of the Committee:

I am Alan R. Nelson, M.D., a physician in the practice of internal medicine in Salt Lake City, Utah. I am a member of the Board of Trustees of the American Medical Association. With me is Harry N. Peterson, Director of AMA's Division of Legislative Activities. The American Medical Association is pleased to have this opportunity to testify today concerning reauthorization of medical education programs under the Public Health Service Act. We are also taking the opportunity to offer our comments on legislation that has been the subject of hearings earlier this month concerning reauthorization of several health programs. Specifically, this statement will present the Association's views on reauthorization of medical education programs and the following bills now pending before the Committee:

S. 2301 - Health Services, Preventive Health Services, and Home Community-Based Services Act of 1984;

S. 2303 - Alcohol and Drug Abuse and Mental Health Service Block Grant Amendments of 1984;

S. 2308 - Primary Care Block Grant Amendments of 1984;

S. 2311 - Health Maintenance Organization Amendments of 1984; and

S. 2281 - National Health Service Corps Amendments of 1984.

REAUTHORIZATION OF MEDICAL EDUCATION PROGRAMS

Mr. Chairman, the AMA believes that the medical education system in this country is second to none and is a fundamental component in assuring needed health care services to the American people. Federal support for medical education and research has been an important factor in achieving this level of recognition. Federal support in the late 1960's and 1970's centered on increasing physician supply through efforts to establish new medical schools, provide assistance to expand and renovate existing schools, assist those schools in financial distress, and provide direct and indirect support of students through financial assistance programs including grants and scholarships, loans and loan guarantees. This infusion of federal financial support was highly successful, greatly increasing the capacity to educate increased numbers of medical students. Near the end of the 1970's the need for this same federal support to increase the capacity to train more physicians came under serious question and direct support of medical schools was significantly reduced through the repeal of start-up assistance for new medical schools, other assistance for major new construction activity, and the capitation grant progam.

Mr. Chairman, the AMA has reviewed the manpower situation and with the rapid rise in the number of physicians over recent years it can be concluded that continued federal stimulus to further increase the capacity to train new physicians is unnecessary. In our view, moreover, decisions in this area should be dictated, to the greatest extent possible, through the application of the market - with government involvement, when appropriate, to carry out its functions in assuring the public health and welfare. That is not to say that government does not have an important role in assisting in medical education today. States, of course, provide substantial amounts of assistance to medical education most directly through operation of and with direct financial assistance to medical schools within their borders. Likewise, the federal government has an important role in continuing to target resources to specific problem areas in medical education, particularly assistance to medical students in financial need so that the medical profession is not closed to all but the wealthy.

It is within the context of increased use of market forces and local resources to make the basic decisions regarding physician manpower--with the federal government offering assistance when necessary to assure that other important goals are met--that we offer our comments today.

INSTITUTIONAL SUPPORT

The AMA encourages continued limited support by the federal government for medical schools. We believe that federal assistance can be a valuable adjunct to other resources in three major areas: assistance for reconstruction and rehabilitation of out-dated facilites; special project assistance; and assistance for institutions in extreme financial distress.

Rehabilitation and Renovation—Some medical school basic science and research facilities are out-dated and in various states of disrepair. In some cases, the facilities can pose safety hazards or are not physically adequate to be used for new equipment or laboratories. With the explosion of new technology and instrumentation, it is critical that medical schools expose their students to the medical state-of-the-art. With inadequate or antiquated facilities, this is not always possible. Therefore, we support continued federal assistance for rehabilitation and renovation of medical school facilities.

Special Projects—Another area where federal support can provide necessary assistance is the support of special projects within medical schools. Such aid supports innovations in medical education that, once demonstrated, can be used in other institutions as appropriate. Authority for such special project assistance should be broad enough to encourage the development of projects that meet unique and innovative needs. Therefore, we support continued special project assistance authority that would allow federal encouragement for new and important changes in medical education.

Financial Distress--While the AMA generally supports the utilization of local resources and the market forces to determine the fiscal viability of medical schools, there are certain situations where we believe direct general financial assistance is appropriate to allow an institution to achieve financial stability. Therefore, we support financial distress grants--for a limited period of time--for those institutions that have unique attributes or resources until they return to fiscal solvency. Such assistance should be used sparingly and only when the institution has certain unique attributes of national significance that would be lost if a temporary financial bridge was not provided to sustain an institution through a financial crisis.

STUDENT SUPPORT

Mr. Chairman, medical education today is very expensive and the costs that an individual can incur in the process can be overwhelming to all but the wealthy. At the upper extreme, medical school tuition in some D.C. area medical schools is now approximately $19,000 per year. That figure covers only tuition and does not account for living costs or other ancillary expenses. Medical school costs are in addition to costs incurred in obtaining an undergraduate degree.

The AMA is concerned that medical education costs could, without assistance, place the medical profession out of the reach of all but the rich. Such an outcome should be avoided. The medical profession--and indeed all of society--benefit from diversity, and we believe this should be encouraged.

Therefore, we continue to support financial assistance to capable students who choose a career in medicine. We support a broad array of assistance, but we believe that in light of the earning potential of a physician that, to the greatest extent possible, federal student assistance should be directed toward loans and loan guarantees. We, therefore, support reauthorization of and adequate funding for the Health Professions Student Loan program (HPSL) and the Health Education Assistance Loan Program (HEAL). These programs offer the necessary assistance for students in medical schools to finance their education. While the Guaranteed Student Loan Program (GSL) is not within the jurisdiction of this Committee, we would encourage all members of the Committee to support continued adequate funding for that program. Many medical students use the GSL program for assistance in financing their undergraduate education and as an adjunct to other financial aid resources during medical school. In addition we believe that in the case of especially needy individuals, it is appropriate to continue the exceptional financial need grant program.

As noted in our comments concerning the National Health Service Corps (NHSC - S. 2281), we do not believe that it is necessary or appropriate to provide for new scholarships for the purpose of obligating service. Such a system is an extremely expensive way to meet manpower needs in select areas and involves extremely long lead times. One of the major problems now facing the NHSC program is the availability of too many physicians with service payback requirements in light of limited resources to fund the field strength necessary to absorb all obligated physicians. Where there may be future manpower requirements for shortage areas, we would suggest that emphasis be placed on the use of loan forgiveness rather than on scholarship programs. We do recommend, nevertheless, that funds be available.

The AMA is proud of the role it has played in establishing a medical education system that is the benchmark by which other systems are evaluated. Through our participation in the voluntary accreditation of medical schools, quality of medical education has remained a principal focus. The federal government has also played a major role in this success and should be commended. We support continued federal involvement in medical education as an appropriate adjunct to the market to assure the continued availability of medical care that the citizens of the United States have come to expect and deserve.

HEALTH PROGRAM REAUTHORIZATIONS

S. 2281 - NATIONAL HEALTH SERVICE CORPS AMENDMENTS OF 1984

S. 2281 would authorize continuation of the National Health Service Corps (NHSC) field program through fiscal year 1987 with funding of $90 million for FY85, $85 million for FY86, and $85 million for FY87. Funding would also be authorized, "as may be necessary," for continuation of funds for existing scholarship recipients for fiscal years 1985, 1986 and 1987 and to make available 150 new scholarship awards for each of these fiscal years. S. 2281 would modify the existing authorization for the issuance of grants and loans to any Corps member who has agreed to engage in the private full-time clinical practice for a period of at least two years in a shortage area. Under the modification, authority to issue grants would be repealed.

The bill also requires the Secretary to prepare and transmit to Congress by October 1, 1985, a plan for the recruitment, employment, and retention of appropriate field strength for the NHSC. The plan is to be developed in consultation with state governments, voluntary organizations, and organizations representing health professionals.

The American Medical Association supports the continuation of the NHSC with adequate field strength to assure the availability of health care in shortage areas. While we are opposed to funding for new NHSC scholarships, since other recruitment techniques (i.e., loan forgiveness, volunteers, etc.) could be made available, we support continued funding for those currently in the pipeline. We also support provisions in the bill which modify the Secretary's loan authority, and we support the proposed NHSC study.

S. 2301 - HEALTH SERVICES, PREVENTIVE HEALTH SERVICES AND HOME COMMUNITY-BASED SERVICES ACT OF 1984.

S. 2301 would reauthorize the preventive health and health services block grant, and the separate tuberculosis, venereal disease, and immunization programs. It would authorize a new home and community-based health services block grant and a three-year demonstration project related to improving emergency medical services for children.

Preventive Health and Health Services Block Grant--S. 2301 would reauthorize the preventive health and health services block grant at these levels: $89 million for FY85, $93.5 million for FY86, and $98.125 million for FY87. This block grant provides states with funds for the following purposes: rodent control; school-based flouridation; hypertension control; community-based programs to demonstrate and evaluate optimal methods of organizing and delivering comprenhensive preventive health services to defined populations; comprehensive programs to deter smoking and alcohol use among children and adolescents, and other risk reduction programs; comprehensive preventive health services formerly provided to states under Section 314 of the Public Health

Service Act; grants and contracts to establish home health agencies in areas where home health services are unavailable; demonstration projects for the expansion and improvement of emergency medical service systems, including services for the treatment of critically ill children; and rape prevention and services to rape victims.

We believe that this block grant should be extended. The creation of a safe environment, promotion of healthful ways of living, and the early detection of diseases have the potential to extend the duration and improve the quality of life of the American people. Successful achievement of these objectives should reduce the costs of health care in both the short run and the long run. Governmental initiatives to prevent illness and disability can support and supplement individual actions, and make the home, workplace, school and community safer and more conducive to healthful living. Federal, state, and local governments should take an active role in the promotion of health and the prevention of disease and disability.

The AMA continues to support the block grant concept which replaced the predominantly "categorical" nature of certain of the federal government's previous efforts to fund public health activities. The previous system of separately mandated and funded categorical health programs for grants to states resulted in excessive federal regimentation of resources. This had the result, in effect, in a determination of local needs through decisions made in Washington with a decrease in state responsibilities in the public health area. The enactment of the block grants helped to begin the process of reversing that trend and also represented an effort to achieve economies in program administration.

The block grant approach gives states greater flexibility to determine their own public health priorities and to address state needs. We believe states are better able to determine the needs of their citizens to target program funding to better meet local needs. We urge Congress to maintain the preventive health and health services block grant.

Categorical Programs--The bill would also reauthorize appropriations for childhood immunization, tuberculosis prevention, and venereal disease prevention for the next three fiscal years. These programs are excellent examples of governmental efforts in prevention of illness. Our Association continues to support and urges reauthorization of these categorical programs.

Emergency Medical Services for Children--The bill also contains a three-year demonstration program at $2 million per year for up to four states to conduct projects to expand and improve emergency medical services for children who need treatment for trauma or critical care.

This new effort to improve emergency medical services for children is also worthy of support.

Home and Community-Based Services--A significant feature of the bill is its creation of a new "block grant" within the prevention block grant for home and community-based services. This grant program would be funded initially at $20 million in FY85 for state planning and start-up, then $150 million in FY86, $200 million in FY87, and $200 million in FY88. Permissible uses of these funds include the following: (1) provision for elderly individuals and disabled individuals of home health services and other health services, (2) activities to coordinate home and community based services provided to elderly individuals and disabled persons in order to eliminate duplication of effort and promote efficient use of funds, (3) the development of procedures to identify elderly and/or disabled individuals--especially those at risk of prolonged hospitalization, or stays in SNFs and such individuals could return to the community if home/community based services were available, (4) determination of the needs of these individuals, (5) recommendations for cost-effective measures to meet those needs; and (6) educating and informing the public regarding available home health service programs.

The American Medical Association strongly supports appropriate home health services and believes that the intent of this program could be beneficial. However, we are concerned about the funding for the direct provision of services and its potential duplication of services under other programs. We believe that if direct provision of services is to be funded, such services should be authorized on a limited demonstration basis--in a limited number of areas with intense follow-up evaluation to determine whether Medicare, Medicaid and other funding sources are adequate to meet appropriate needs.

S. 2303 - ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH SERVICE BLOCK GRANT AMENDMENTS OF 1984.

This bill would reauthorize the Alcohol and Drug Abuse and Mental Health Services Block Grant for the fiscal years 1985, 1986 and 1987. Currently the block grant is authorized through fiscal year 1984.

Authorizations--The bill would authorize the following levels of funding: FY85 - $472,300,000; FY86 - $486,469,000; and FY87 - $501,063,000.

"Set Asides"--The original block grant authority established a "set aside" for utilization of block grant funds by the states. These set asides required the states to continue to fund certain activities in relative proportion to the way those activities were funded prior to enactment of the block grant. Those set asides retain the percentage of funds going to Community Mental Health Centers, Alcohol Abuse, and Prevention. The bill extends these set asides until the end of FY87.

In our view, the block grant concept can best be carried out by allowing states to target resources in the manner best suited to meet local needs and conditions. The set asides now in the law were seen as a necessary transition to total state discretion in this area. We believe that continuation of the set-asides defeats the intent of block grant legislation; accordingly the set-asides should now be eliminated.

Services Relating to Drug and Alcohol Abuse in Women--The bill establishes authority for demonstration programs targeted at prevention of and treatment for alcohol and drug abuse in women, including homemakers, single mothers, divorced mothers, widowed mothers, displaced homemakers, and pregnant women.

We are aware of growing concerns about increased abuse of drugs and alcohol by women. However, we believe that it is inappropriate to focus only on limited groups while other categories of women would be excluded as potential beneficiaries of a demonstration program. In our view, any such program should include all women in need of special assistance in combating alcohol or drug dependency.

The American Medical Association supports reauthorization of the Alcohol and Drug Abuse and Mental Health Services block grant and the demonstration program concerning prevention and treatment of alcoholism and drug abuse in women, with modifications to assure that no women in need of these prevention services are arbitrarily excluded.

S. 2308 - PRIMARY CARE BLOCK GRANT AMENDMENTS OF 1984

This bill would continue the program for Primary Care block grants and make changes as noted below.

Authorizations--The bill would authorize $340 million for FY85, $345 million for FY86, and $350 million for FY87 for allotments and grants to states. The block grant had been authorized at $327 million for FY84.

State Matching Requirement--The state's matching requirement for grants to Community Health Centers and for administrative expenses would be reduced to 10% for each of fiscal years 1985-1987. In FY83 the matching requirement was 20% and in FY84 it was 33%.

We note that the high matching rate under the original program has discouraged states from accepting this block grant and that the program is still generally operated at the federal level.

Community Health Centers--The bill would extend through FY87 the requirement that states continue to contract with existing Community Health Centers.

In our view, states should be allowed to operate the block grants with flexibility to meet individual state needs.

We support the reauthorization of the Primary Care block grant, with the above reduction in the state matching requirement. The requirement that states continue to contract with existing Community Health Centers should be eliminated.

S. 2311 - HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1984

This bill makes several technical changes in the Health Maintenance Organization Act.

Repeal of Loan and Grant Authorities--Continuation of Loan Guarantee Fund--The bill would repeal those sections of the HMO Act that allow for grants, loans, and loan guarantees for feasibility and initial development of HMOs. Also repealed is the authority (beginning October 1, 1984) for loans and loan guarantees for construction and acquisition of ambulatory facilities by HMOs. The bill would, however, allow such transfers from the General Treasury as needed in order to fund the existing HMO loan guarantees. Also, authorization is provided for the next three years to fund such loans and loan guarantees as necessary to complete the cycle of funding for those HMOs that were in the assistance cycle prior to October 1, 1981.

The AMA supports these provisions. We believe that general government financial assistance to promote further HMO development is no longer necessary. A recent study has found that enrollment in HMOs reached 12.5 million persons in June 1983, a 15.3% increase over the previous year and the largest annual increase since 1978. Moreover, we do not believe that government policy should favor one particular health care delivery mode over another. It should, as much as possible, strive for policy neutrality.

Board Composition for Private HMOs--S. 2311 would delete the requirement that one-third of the Board members of an HMO come from the membership of that HMO.

One of the major underlying concepts of the initial HMO program was patient participation. The Board membership requirement was designed to effectuate that philosophy. While we understand that the new environment for HMOs has changed considerably and that the "one-third" Board member requirement may no longer be generally practical, we continue to be concerned about the need for HMO members to maintain an active role in the HMO and have a method of providing input into operations and resolving grievances. The AMA can support the elimination of the Board requirement if assurances are provided for appropriate patient protection and grievance resolution systems.

Periodic Requalification--The provision in the Act that requires an HMO to be periodically requalified (every two years) would be deleted. The AMA supports elimination of the periodic requalification requirement shoud provide for adequate procedures to ensure continued and regular review of the quality of care and the fiscal solvency of "qualified" HMOs.

Supplemental Services--The bill would authorize an HMO to offer supplemental services on an experience-rated basis. The law currently requires such services to be rated on a community rating basis.

The AMA is concerned that a break with the philosophy of community rating would create the potential for market skimming. We recommend that this new proposal be deleted from the bill.

Limitation on Source of Funding--The provision of the Act which prohibits the use of other Public Health Service Act funds to finance feasibility, planning, and initial operation of HMOs would be repealed.

We also support this provision in S. 2311. The same reasons that exist for repeal of the HMO loan and grant authorities mentioned earlier suggests repeal of these sections as well. Moreover, we believe that in this period of budgetary restraint within the Public Health Service, resources should not be diverted from their more essential missions.

CONCLUSION

The American Medical Association appreciates the opportunity to submit its views today concerning the reauthorization of medical education programs and the reauthorization of other programs under the Public Health Service Act. The AMA supports major portions of the legislation currently before the Committee. We urge the Committee to carefully review our comments and consider such changes as necessary to reflect these views.

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AMERICAN MEDICAL ASSOCIATION
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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

March 30, 1984

The Honorable Orrin G. Hatch
Chairman
Committee on Labor and Human Resources
U.S. Senate
Room 428 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Committee Questions Concerning
Medical Manpower

Dear Senator Hatch:

This letter is in response to written questions submitted to the American Medical Association as a follow up to the appearance of Alan R. Nelson, M.D., before the Committee on Labor and Human Resources at a hearing March 14, 1984, concerning health manpower issues.

You have asked three questions concerning AMA views and information on specific manpower issues as follows:

1. What is the AMA's position regarding the overall number of health care providers? Do we need more, or less? Who should be responsible for determining how many health care providers we educate? And license?

   The AMA has not, nor does it currently, set targets on the aggregate number of physicians or numbers in specific physician specialties. There are numerous reasons why the Association does not set manpower targets, principal of which are our concerns that national targets do not respond to or recognize individual patient care requirements or local needs and circumstances. We are also concerned that with the rapid changes in medical practice and technology forecasts based on current medical practice are difficult to make and tenuous at best. In light of the extremely long lead time in physician training, any error in forecasts could have long-term affects that would take extended periods to correct.

   Rather than attempt to control physician supply through the use of arbitrary controls based on tenuous projections, the AMA believes that to the greatest extent possible the number, specialties, and distribution of physicians should be set through the operation of the marketplace. The AMA has completed a study on this issue, and our report of that study is included with this letter for your review and information. It should be noted that the increasing number of physicians already has provided a substantial increase in access to medical specialists in rural areas.

2. Does the AMA provide student loans or scholarships?

At this time the AMA does not provide direct loan or scholarship assistance to students. The AMA Education and Research Foundation (ERF) did provide loan guarantees for medical students from 1962-1980. During that 18-year period, more than 75,000 loans valued at more than $95 million were guaranteed. Economic conditions in 1980 forced suspension of this program by discouraging bank participation in the program.

The AMA-ERF has initiated an ongoing program to solicit and disburse funds to medical schools with the funds so collected restricted to student assistance. In its first year of operation this fund attracted and distributed $229,000. In light of the fact that this is a new program, we expect that amounts collected and disbursed for student assistance will increase substantially in the coming years.

The AMA Education and Research Foundation also disbursed $1,292,000 in unrestricted funds to medical schools in 1984 to help support continuing excellence in medical education. We expect that some medical schools will use some or all of these unrestricted funds from the AMA-ERF for student assistance.

3. As you know, the cost of a medical education has increased dramatically over the past several years, and there are growing concerns that student indebtedness will affect career choice, with more students choosing the high-paid specialties. Does the AMA have data related to student debt and ultimate career choice?

The AMA recently completed a detailed study of this issue, and a report was received and filed by our House of Delegates in December 1983. A copy of the report is attached for your review. The report concludes that at this time "no clear relationship between debt and career choice appears to be present." The Association will continue to monitor and study this important issue.

The AMA appreciated the opportunity to appear before the Committee and is pleased to provide additional information on these important issues. If we may be of further assistance, please feel free to contact us.

Sincerely,

James H. Sammons, M.D.

JHS/dap
Attach.
1376p

C. HEALTH MANPOWER

(Reference Committee C, page 262)

HOUSE ACTION: ADOPTED AS FOLLOWS AND REFERRED TO BOARD OF TRUSTEES for a continuing study of the effect of market forces on physician supply, and for a further report to be submitted by the Board of Trustees at the 1982 Annual Meeting

At its 1981 Annual Meeting, the House of Delegates adopted Report AA of the Board of Trustees. This report stated the Board's intention to reexamine Association policies on health manpower and report to the House at its 1981 Interim Meeting. With consultation from the Councils on Medical Service, Medical Education, and Legislation, the Board of Trustees reviewed health manpower policy issues. The following report contains the results of that systematic reassessment promised in Report AA (A-81).

INTRODUCTION

During the last decade, the Association has monitored and analyzed manpower developments. In 1971, the House of Delegates adopted "Physician Manpower and Medical Education." A second report, "Physician Manpower and Medical Education, II," was adopted in 1978. This report is the third in that series. These reports, and the recommendations they contain, outline Association efforts to influence national policies affecting the production and distribution of health care resources.

In the last decade there have been dramatic increases in health manpower resources:

- The number of physicians has grown faster in the 1970s than in previous decades, increasing significantly more rapidly than the population as a whole.
- There has been even more rapid growth in the number and types of allied health manpower.

Since these changes inevitably affect the practice of medicine, Association policy must be reviewed for its relevance in this altered environment.

The rising cost of medical education is another aspect of recent history that motivates this reassessment of AMA policy. As the federal and state governments have reviewed their spending priorities, they have reduced support for medical education. Medical schools and medical students alike have felt the effects of reduced funding levels. Because the graduates of the medical education system are a primary determinant of future supply of services, the Association must develop policy that can address this new set of issues.

The principles presented in this report are similar to those enunciated in the two reports of the previous decade as well as earlier statements of AMA policy. In addition to examining medical education issues, however, this report focuses on the role of health manpower in the production and allocation of medical services. The emphasis has changed in order to adapt the Association's basic philosophy to rapidly changing external events. As a group, the principles in this report are based on:

- respect for individual decision making and market processes;
- commitment to quality medical education in a pluralistic society; and
- recognition of the appropriate role for allied health manpower.

In developing this report, the Board has paid careful attention to the issues of:

- centralized versus decentralized decision making;
- physician population – size and composition;
- medical education – autonomy, quality and finance; and
- allied health manpower – roles and distribution.

The body of this report contains explanatory material about each of the principles grouped in the four issue areas. The implications for AMA programs are described in the concluding section.

APPROACHES TO MANPOWER ISSUES: CENTRALIZED VERSUS DECENTRALIZED DECISION MAKING

AMA's concern with health manpower issues grows out of the more general desire to provide quality medical care to the American people. The distribution of medical services is inextricably linked to the distribution of physicians and allied health personnel. Thus, the career decisions of these professionals are critical in all manpower issues and in the provision of medical services to the public.

Recognizing the difficulty of responding to the complex health care needs of the public with centralized planning, the AMA has a long tradition of favoring a decentralized approach to health manpower issues. There is, however, awareness of the special nature of the medical care sector. The high value placed on medical care in this country is the reason for extensive professional self-regulation and licensure. Beyond those quality assurance activities, support for maximum individual autonomy is basic to AMA policy.

The Association's commitment to quality medical care and quality medical education is independent of any manpower requirements. Criteria for accreditation of medical schools and residency programs are based on professional judgments of appropriate educational standards. These standards are not adjusted to reflect changing societal conditions. Instead, organized medicine upholds a fundamental professional responsibility to ensure that only qualified individuals enter the practice of medicine.

The term "market" is used throughout this report and needs further explanation. In general, **a market involves decentralized decision making by buyers and sellers.** These decisions are voluntary choices for both parties to any exchange of goods and services. The situations that occur in the exchange of particular goods or services give rise to a wide variety of institutional arrangements in different markets. Many of these arrangements help to coordinate buyers' (consumers') and sellers' (providers') decisions and ensure that their choices are mutually consistent. Unfortunately, the complexity of the institutional interactions can often obscure the fact that markets, even those in the medical care delivery system, ultimately respond in predictable ways to the underlying forces of supply and demand.

There are several markets that constitute the medical care delivery system, including the markets for:

- health care services;
- health care employment; and
- health professions education.

Taken together they form **a self-adjusting mechanism for determining the flow of resources in the medical care delivery system.** These market mechanisms function by producing signals in the form of professional and economic incentives for health care providers and consumers. If freed from extensive government regulation, these markets can provide an environment in which cost-effective medical care is the rule rather than the exception.

For example, physicians choose a location or specialty based in part on their perceptions of the current and future professional outlook. Their choices will be guided by the same factors that a centralized agency would attempt to consider: the potential patient population, the ability of an area to support the practice, the degree of professional support, and the extent of related health facilities. However, because individual physicians have a personal interest in the success of their decisions, they, as opposed to a centralized planning agency, are more likely to seek and utilize relevant information.

The market for medical care is complicated by the prominent decision-making roles played by institutions such as insurance companies, hospitals and government. Each of these institutions may facilitate or impede market processes, but they cannot alter some of the fundamental interrelationships. For example, increasing supply of services relative to demand will adversely affect existing suppliers, regardless of the institutional structure.

The government as a purchaser of services has a legitimate role in the market. Society may choose to help the financially disadvantaged by instituting government programs that subsidize their access to medical care. The AMA has supported these activities under certain circumstances. Governmental reimbursement policies in these programs, for example, will affect behavior through a market process. The fact that its internal decisions involve a political element in no way makes the government an inappropriate participant in the market.

Support of basic medical research is another legitimate role for government. In the past, public support for medical research has been funded, in part, by the payment for medical services provided by teaching hospitals. Should reimbursement policies, or government subsidy programs change substantially, then alternative methods should be found to finance basic research. Thus, a limited, legitimate role for government does exist. However, if government attempts to constrain the behavior of other market participants, its action would impede market processes.

In a different context, the "market" for medical education involves institutional participants – medical schools, teaching hospitals, individual residency programs, accrediting agencies, and the government – in a lengthy process that tends to increase the time necessary to respond to market changes. The complexity of the system and existence of substantial time lags do not negate market forces. In fact, the ultimate effects of market forces will be, to a considerable degree, independent of the institutional arrangements.

Interested public and private organizations can make a valuable contribution to this market process. In order to respond quickly to changing incentives, providers and consumers rely on the information that is available to them. The accuracy of the information and the speed with which it is disseminated are important aids to market mechanisms. In particular, **the AMA can play an important role in facilitating the workings of the markets in the medical care sector, even though it is neither a buyer nor a seller.** To facilitate an appropriate allocation of medical care resources, the Association can:

- provide relevant information to other participants more directly involved; and
- represent physicians-in-practice as well as in-training to other involved institutions.

A troubling aspect of the changing environment is the stress that has grown among groups of physicians. The allocation of hospital privileges is a decision that often involves conflicts among some groups of physicians. These conflicts may intensify because of increased supply relative to demand. The AMA can facilitate the market solutions to these issues by aiding the communication between different factions.

The AMA recognizes that the current economic environment has caused and will continue to cause unmet expectations for many participants in the medical care sector: physicians, medical students, medical schools, the government and the public. Each of these groups seeks a satisfactory resolution of its potential problems. In particular, some would prefer that there be more direct control over the allocation and distribution of health care resources.

It is preferable, however, to rely primarily on market mechanisms rather than regulatory alternatives to:

- accommodate these often conflicting desires; and
- bring about an adjustment to shifting external circumstances.

Under regulation the resolution of conflict is essentially political, often depending on the size of the affected group. In addition, regulation, far from eliminating adjustment problems, has frequently exacerbated them. **Those physicians and providers of medical care who have experienced difficult adjustments to changing market forces should not be misled into believing that a regulatory solution exists.**

> Principle 1: In the absence of extensive regulation, the dynamic forces of the marketplace produce major incentives for the appropriate production and distribution of medical care services. The AMA supports the operation of self-adjusting market mechanisms that are consistent with quality medical care.

PHYSICIAN POPULATION

Groups with different perspectives have been monitoring changes in the delivery of medical care. Most recently, under government auspices, the Graduate Medical Education National Advisory Committee (GMENAC) investigated the topic of health manpower supply and issued a report stating that there will be a substantial surplus of physicians by the year 1990. GMENAC's conclusions were derived from the application of a technically sophisticated but traditional approach to manpower problems. Fundamentally, the analysis used by GMENAC consisted of an attempt to project future health care "needs" and compare them with the expected future supply of physicians' services. The GMENAC definition of health care "needs" represented a middle position between what they believed was needed and what was reasonably achievable.

Using variations of the traditional manpower approach to forecast the future status of physician manpower may lead to an underestimate of the ability of the health care delivery system to adjust to a changing environment. There is significant interaction among the various components of the changing environment, including interaction among:

- new technologies;
- revised concepts of adequate health care;
- innovative practice management approaches; and
- the growing supply of physicians and allied health care professionals.

The result may be a medical services marketplace radically different from the one assumed in the GMENAC projections. As a result of these reservations, the AMA does not believe that highly centralized manpower planning in general, and the GMENAC approach in particular, is an appropriate way to address the issues facing the nation.

Nonetheless, the rapid rise in the number of physicians in the past decade has been well documented. The number of nonfederal physicians per 100,000 civilian population has risen from 152 in 1971 to 194 in 1979. The physician shortage proclaimed by the 1959 Report of the Surgeon General's Consultant Group on Medical Education (the Bane Report) and the 1970 Report of the Carnegie Commission on Higher Education is no longer so apparent. This was perceived by the AMA-sponsored National Commission on the Cost of Medical Care which produced one of the first major reports to note the changing trend. The capacity of the physician population to meet demands for medical care is substantially better than before, and current trends are likely to continue in the near future.

As the conclusions of various public and private health manpower commissions have shown, forecasts of needs and future demand are fraught with difficulty. Changing public policy and technical innovations can dramatically alter the perceived medical need for the population. For example, the implementation of the Medicare and Medicaid programs and the development of the Salk and Sabin polio vaccines illustrate how rapidly and unexpectedly demand for medical care can change. The changes are not limited to overall increases or decreases; the demand for different types of health manpower can shift dramatically with no overall modification.

On the supply side, it is evident that physicians respond to the incentives in the current medical and economic environment:

- Prospective medical students, particularly those from low-income families, are beginning to question their abilities to complete a medical education, given the recent reduction in scholarships and subsidized loans and the rapid increase in medical school tuition. These circumstances may make medicine a relatively less attractive career alternative.
- Physicians completing their graduate medical training are taking longer to find satisfactory first practice positions, due to the rising cost of establishing a medical practice.
- Younger physicians are foregoing careers in medical research partly because of decreased federal funding.

In addition, if the quality of the work environment experienced by older physicians deteriorates, the number opting for early retirement is likely to grow.

These examples of responses to market forces show that long-run projections of physician manpower demand and supply are vulnerable to unexpected events and changing circumstances. The persistence of these fluctuations confirms the wisdom of the health manpower policy that the AMA adopted in 1951 ("AMA Policy Regarding the Production of Physicians").

Markets can favorably or adversely affect participants; these positive and negative incentives are essential for the market to efficiently allocate resources. The increase in the number of physicians has not been uniform in terms of either specialty or geography. Thus, allowing the market mechanism to work may adversely affect some physicians. Some may:

- find themselves located in an area with many other physicians who are trying to serve the same patients;
- experience fewer patient visits and lower incomes; or
- discover that demographic shifts, insurance reimbursement policy changes, or shifts in demand make their current specialty less attractive than previously.

These circumstances may not be pleasant, and appeals to the common good produced by the market will do little to assuage those directly affected.

Rather than passively waiting for market forces to operate, however, organized medicine should actively assist physicians in identifying those geographic areas desiring physicians and assist physicians in responding to those desires. In addition, organized medicine should provide communities with assistance in attracting physicians and making medical practice in their areas feasible and practical.

> Principle 2: The numbers of physicians should, insofar as possible, be determined by processes of the market. The AMA will help physicians adjust to changing circumstances. This commitment entails the collection, analysis, and dissemination of information required by physicians and other market participants in order to make informed decisions.

(Board of Trustees – C)

MEDICAL EDUCATION

Medical education determines the future of medicine in the United States through its impact on the number of physicians being trained, the quality of the training they receive, and the focus of the training on broad based or specialty activities. Because of the length of time between admission into medical school and establishment of a practice by a new physician, any policy changes made in this process necessarily yield results only after a time lag as long as seven to ten years. The existence of this long lag does not mean that market forces are not operating. Those forces are at work, affecting the choices of both students and schools. The effects, however, are seen years after the initial stimulus.

Although there is a long interval between the entrance of a new student into medical school and the establishment of a medical practice at the completion of training, students have considerable flexibility during that period. The choice of specialty, for example, is typically accomplished within a three-to-five year period after graduation. Studies of the graduate medical education system reveal that switching specialty is a frequent phenomenon. As individuals learn about their own talents and the opportunities available, they make appropriate adjustments. Thus, although there is a long lag inherent in the system of training, it is comparable to lags in other highly skilled manpower markets.

Market forces have their effects on medical schools as well as students. Rising educational costs coupled with declining amounts of government support have forced many faculty and administrative decision-makers to take greater account of the economic consequences of their actions. These difficulties are evidence of the impact of market forces on the educational establishment. Providing high quality education in these circumstances requires considerable skill.

Since its founding, the AMA has been involved in the medical education process. This history includes the initiation in 1906 of a program by the Council on Medical Education to inspect and classify American schools of medicine, and more recent participation with other professional groups in the Liaison Committee on Medical Education. This effort has concentrated on ensuring that acceptable quality training is provided to medical students in the United States.

The AMA supports the view that a medical school should determine the number of students that it admits. The determination of whether a new medical school should be established or an existing institution be continued requires the local initiative of a university, a medical society, or a community. This position was formulated in the 1951 "Policy of the American Medical Association Regarding the Production of Physicians," and has been reaffirmed in 1971 and 1978. The current reassessment indicates that the 1951 policy continues to be appropriate.

> Principle 3: The number of U. S. medical schools should be determined by the availability and allocation of resources and the ability of schools to meet acceptable educational standards. The number of students admitted to individual schools is and should be determined by the faculty and administration of each medical school.

The rapidly changing economic and technological environment suggests that physicians must be able to maintain their flexibility in order to respond to major changes. As a result, it is important for physicians-in-training to obtain a broad scientific and clinical background to complement their specialty training.

This broad base of medical training will allow physicians to shift the focus of their practices in the future, if the need arises, in order to serve a different patient population or to address the evolving needs of their existing patient load.

> Principle 4: Medical education should be sufficiently broad to enable practicing physicians to adapt their practice patterns to the changing needs of the population and changing medical technology.

All medical students, and particularly those from low-income families, are encountering increasing difficulties in financing their education. Programs that assisted students in recent years are being redefined, reduced, or eliminated for the 1981-1982 school year. In particular, scholarship aid, subsidized loan funds, most federal programs, and some state programs have been significantly altered. The scale of the void that will be created by these reductions may frustrate the efforts of those who would attempt to replace government monies with funds from other sources.

As the out-of-pocket costs of a medical education rise, students will attempt to cope in a variety of ways. The cost of a medical education and related expenses vary widely by medical school, individual living standard, and personal situation. Thus, the choice of attending a more expensive school in a costly location is essentially a voluntary decision by the student for which he or she must accept responsibility.

In any case, it appears likely that students increasingly will be forced to consider the cost of medical education when they submit their applications. Qualified students from disadvantaged backgrounds are of particular concern. Those students already pursuing a medical career will be forced to commit more of their own resources than expected. The Association realizes the significance of this problem.

> Principle 5:The AMA encourages development of a variety of innovative financing mechanisms to assist medical students who are faced with high cost and dwindling sources of financial aid.

The provision of quality medical care is essential to meeting the health care needs of the nation. Since its founding in 1847, the AMA has been a leader in developing and advancing standards for the education of physicians and for the quality of medical care. The AMA has consistently pursued this goal through its:

- efforts in conjunction with other organizations to accredit American medical schools, graduate medical training institutions, and continuing medical education programs;
- support of state programs to license physicians through formal boards of medical examiners; and
- endorsement of peer review programs.

These efforts provide an important service to the public and the profession by assuring appropriate standards for professional practice.

Consistent with this philosophy, **the AMA has opposed the application of the accreditation, licensure, and other quality assurance procedures for any purposes other than ensuring the quality of care.** Six states now issue licenses by specialty, although few physicians have chosen this option, and none of the states has restricted practice in a specialty to those who have been licensed in that specialty. Several state legislatures have considered, however, using their state licensing process to limit the number and specialty distribution of physicians within their states.

The AMA believes that the public in a democratic society can best be served by an educational system that maximizes the freedom of individuals to choose and develop their career interests and opportunities. This precept applies to both the selection of medicine as a career and the choice of specialty.

> Principle 6: The medical profession has an ongoing responsibility to ensure the quality of care and the maintenance of appropriate standards for medical education at all levels. Quality assurance procedures should be used solely for their stated purposes.

(Board of Trustees – C)

ALLIED HEALTH MANPOWER

In keeping with the concern for quality medical care, AMA policy has focused on both the physicians and the allied manpower who are involved in the delivery of medical services. The role of allied health manpower has been recognized and supported by the medical profession for many years.

There are a number of important distinctions to be made among different types of allied health professionals. In this report, the discussion is limited to those categories of health care personnel who perform patient care functions upon the order of or under the direction and supervision of a physician, but are not licensed as independent health care practitioners. AMA recognizes that other non-physician, independent practitioners are licensed by the state to perform specific health care services. For the groups addressed in this report, however, the same principles that guide AMA policy on the size and distribution of the physician population can and should be applied.

Reliance on market forces in this area, as was the case with physician-specific issues, means that potential job satisfaction and income prospects, when compared to educational costs, will lead potential allied health personnel into appropriate career patterns. No agency, public or private, will be able to determine the appropriate number of practitioners for different professions.

There is, once again, a central role for organizations like the AMA in disseminating reliable information on alternative careers. Individuals, particularly young people deciding on a career, need information on which to base their career decisions. In keeping with the recommendations concerning physicians, the AMA believes that it is appropriate to collect and widely disseminate the information that will aid interested individuals contemplating careers in the allied health professions.

> Principle 7: The number and distribution of allied health manpower should be determined, insofar as possible, by processes of the markets. The number of training programs should be determined by the market and the ability of each program to meet acceptable educational standards applicable in the United States. The number of students enrolled should be determined by the faculty and administration of the individual training institution. In addition, information about career prospects should be collected and widely disseminated by interested organizations, including the AMA.

The physician has the ultimate legal and ethical responsibility for the medical care of his or her patients. AMA policy recognizes that allied health manpower also have legal and ethical responsibilities to the patient. Moreover, it is the position of the AMA that direct physician supervision is not required for all services performed by allied health personnel. With the increased specialization of modern health care, however, it is advantageous to have one individual with overall responsibility for the medical care of the patient. The physician is well suited by professional preparation to assume this leadership role.

It is important to determine which specific medical procedures or functions can be performed only by physicians and which can be performed by specialized categories of allied health personnel with specific levels of physician supervision. AMA policy encourages continued dialogue between physicians and allied health manpower at state and local levels to determine the extent of responsibility and scope of functions to be assumed by such practitioners which are conducive to the best care of patients.

Reliable mechanisms should exist to ensure that individuals in each profession possess medical skills commensurate with the patient care functions that may be delegated to them. Quality assurance of allied health professions should be met through accreditation of educational programs and voluntary credentialing mechanisms.

Accreditation is a voluntary process and should be conducted by appropriate associations of health care professionals who have the background and knowledge necessary to evaluate educational programs. The AMA should continue to play a significant role in the accreditation of educational programs for allied health professions to ensure appropriate regard for the impact of coming changes in medical practice.

Voluntary certification programs which evaluate the qualifications of individual allied health personnel are another means of providing public assurance of quality health care. Voluntary certification of allied health workers who function under medical supervision is preferable to licensure because it permits greater flexibility in their utilization. There is little justification for state licensure of allied health personnel who work under the supervision of a licensed physician.

> Principle 8: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency.

AMA ROLE

Consistent with the prime function of the American Medical Association to represent physicians, strongly endorsed by the House of Delegates at its Annual Meeting in June 1981, the AMA shall continue and extend its essential role in analyses and assessment of health manpower in its relationship to medical and other services for the restoration and maintenance of health, and to the resolution of issues related to the availability of timely and effective services for the health of the public. The AMA must maintain its preeminent position among the several bodies and institutions addressing and responding to the complex issues of health manpower.

> Principle 9: The AMA has realized the dynamic forces of the marketplace; however, it recognizes that market forces can be altered. The AMA acknowledges the authorities and responsibilities of educational institutions and the functions of government. The AMA maintains an essential interest and role in health manpower assessment and planning in whatever setting this may occur. The AMA will work closely with institutions responsible for medical education and allied health education, legislatures, governmental and non-governmental agencies and organizations, and the constituent state and county medical societies wherever planning and the resolution of problems related to medical and other aspects of health care occur.

IMPLICATIONS

On the basis of these principles, the Association will implement or continue a series of programs designed to promote the well being of the profession and the public. These programs will:

- monitor trends;
- analyze and disseminate relevant information; and
- represent the profession's positions in policy-making forums.

Monitor Trends

The AMA has collected and disseminated information about physicians for over seventy years. Today the Association is considered to be the most comprehensive source of information on physicians in the United States. The Record of Physician's Professional Activities (PPA) has collected information on physicians' professional activities, their area of specialization and their current employment on an "hours worked per week" basis. The 1981 PPA Census which is currently underway will continue to maintain a current and comprehensive basis for monitoring trends in the physician population.

Since 1900, the American Medical Association has collected and published an extensive collection of information on the detailed operation of the medical education system. The annual edition of JAMA which contains a description and analysis of the undergraduate, graduate and continuing education system is the authoritative source on physician education. In addition, the AMA publishes the annual "Directory of Residency Training Programs" which details the number and types of graduate training programs.

For the past fifteen years the AMA has been collecting information on the practice patterns of physicians. The basic monitoring activity will soon be enhanced by the implementation of a Socioeconomic Monitoring System (SMS). SMS will provide information on physicians' fees, utilization rates, number of hours worked, number of patients seen, and other practice patterns. This system, based on telephone interviews of physicians, is designed to be flexible enough to collect data throughout the year and produce timely reports on current issues.

For other health services workers, the Association will explore cooperative ventures for the collection of information. This is in addition to the "Allied Health Education Directory" which the AMA compiles and publishes each year. This volume provides the details of the education and training programs of twenty-six allied health occupations.

Analyze and Disseminate Information

Analysis and distribution of information has been an important source of the Association's ability to influence events. AMA publications on the distribution of physicians and the socioeconomics of health care give the Association the opportunity to provide important services to members and the public.

Placement services that help match physicians with suitable practice opportunities are of great value to the profession, particularly to those physicians in transition. In addition, many physicians can benefit from advice on improving the business side of medical practice. Starting a new practice, improving an existing one, or closing a practice all involve unique problems for an individual professional. The AMA and other interested organizations have much to offer in the collection and dissemination of these different types of information.

A program providing current information to college career counseling officers about the various health professions will be implemented. This program would ultimately provide young people with the information they need to make intelligent choices about their career alternatives.

Exploration of possible physician retraining programs is also indicated. The rapidly changing environment creates the need for intensive training of established physicians wishing to change their professional focus. The AMA, perhaps with other interested organizations, will explore the feasibility of meeting this need.

Represent the Profession

An important function for AMA activities on health manpower is to represent the physicians' view that a market-oriented approach to health manpower is, in general, the correct basis for policy. This message must be forcefully delivered to those who would advocate the arbitrary determination of:

- the number of physicians, nationally or locally;
- the number or size of U. S. medical schools; and
- the number of allied health manpower.

The AMA can play an important role in facilitating the workings of the market. The principles in this report outline the Association's response to the general policy issues that arise, and offer guidance for responses to particular proposals.

REPORT OF THE BOARD OF TRUSTEES

Report: E
(I-83)

Subject: Educational Indebtedness and the Career Choices of New Physicians

Presented by: John J. Coury, Jr., M.D., Chairman

Referred to: Reference Committee C
(Edgar T. Berry, M.D., Chairman)

At its 1982 Annual Meeting, the House of Delegates adopted Report U of the Board of Trustees, which summarized the most recent information on the effects of indebtedness on medical students and resident physicians. Report U also outlined a plan for the AMA to collect and analyze additional information. This report was adopted in lieu of Resolution 82 (I-81) introduced by the Medical Student Section, which called for the development of a "research protocol that will collect information . . . on characteristics of students . . . and assess the relative importance of various factors (including indebtedness, income potential, and family background) in determining the specialty and location choices of young physicians."

In response to Report U, the AMA developed a three-part research program to investigate the effect of high and rising educational costs on medical students and resident physicians. The first part of this program was completed with Report P (A-83) of the Board of Trustees. This report examined data on medical students' indebtedness collected by the Association of American Medical Colleges. The research program has two other phases:

- an examination of the actual career choices of physicians originally interviewed in the 1979 Survey of Resident Physicians; and

- the analysis of data on indebtedness, graduate medical training, and career plans collected through a new survey of resident physicians.

This report presents initial results from each of these phases of the AMA research program.

EDUCATIONAL INDEBTEDNESS OF NEW PHYSICIANS

Many individuals and organizations have voiced concerns about the potential effect of indebtedness on the career decisions of new physicians. High debt loads, it is argued, may force physicians-in-training

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Past House Actions: A-83:56-60; A-82:57-59; I-81:242

to alter their career plans so that fewer will choose careers in research or general practice and more will opt for higher paying specialties (e.g., surgery, radiology, anesthesiology) and will practice in metropolitan areas. Both the 1979 and 1983 Surveys of Resident Physicians provide data that can be used to examine the relationship between debt and career choices. It is particularly useful to examine both the 1979 and 1983 surveys, since increasing debt loads may have altered patterns of behavior over time.

The following conclusions have been reached from an initial analysis of the 1979 and 1983 Surveys of Resident Physicians:

- The average level of medical educational debt of new physicians is quite high and has been increasing (average debt of resident physicians in 1979 was around $13,300 and has increased to over $18,200 by 1983).
- Though variations in mean level of debt do exist for certain categories, the variations are not large and may not explain differences in new physicians' career decisions.
- Those with relatively high debt do not appear to choose more remunerative specialties or practice locations with greater frequency than those with lower debt.

These findings are consistent with those presented in Board of Trustees Report P (A-83), and with the conclusions reached by articles published in the professional literature (e.g., French [1981]; Korcok [1983]). The discussion that follows describes the surveys and examines the specific results that led to these conclusions.

1979 Survey of Resident Physicians

In 1979, the AMA conducted a survey of resident physicians. Questionnaires were sent to a randomly selected sample of approximately 10,000 residents, of whom 35 percent responded. Approximately 3,000 of the respondents were actively practicing medicine in the spring of 1983. Information on current specialty, practice location, and practice modality on these individuals was obtained from the AMA Physician Masterfile. Tables 1 and 2 present basic tabulations of indebtedness by the career choices made by respondents to this survey.

Table 1 presents two indicators of debt load: the percent of physicians with some medical education debt and mean debt for this portion. Thus, 63.7 percent of the physicians examined incurred some debt during their medical education; for this 63.7 percent, the average debt was $13,300.

Table 1

Percent of Resident Physicians Surveyed in 1979 with Medical Education Debt and Mean Debt by 1983 Practice Location, Modality, and Specialty

	% WITH MEDICAL EDUCATION DEBT	MEAN DEBT OF THOSE WITH SOME DEBT
TOTAL	63.7%	$13,300
Census Division*		
New England	62.2	13,700
Middle Atlantic	60.6	14,600
East North Central	64.1	11,800
West North Central	70.2	13,600
South Atlantic	62.8	13,300
East South Central	69.5	11,900
West South Central	59.5	10,800
Mountain	65.9	14,000
Pacific	66.2	14,300
Practice Location		
Urban	63.3	13,200
Rural	67.5	13,700
Practice Modality*		
Solo	63.4	16,000
Partnership	62.5	14,300
Arrangement Non-Group	68.0	12,000
Group Practice	68.8	12,100
Hospital-Based	58.8	12,300
Medical School	63.3	13,300
Specialty*		
General/Family Practice	72.1	14,500
Internal Medicine	63.7	13,200
Surgery	60.9	12,400
Pediatrics	71.3	11,400
Obstetrics/Gynecology	66.3	15,500
Radiology	55.8	13,000
Psychiatry	56.8	15,700
Anesthesiology	59.1	13,000
Other	63.6	12,000

Source: 1979 Survey of Resident Physicians and 1983 AMA Physician Masterfile.

*Means within category significantly different at .05 level.

Table 1 also reports the relationship between debt load and different career characteristics of new physicians. With respect to practice location, those in the Middle Atlantic census division have the highest average debt ($14,600) while those in the West South Central region have the lowest average debt ($10,800). However, the mean debt load of those locating in urban settings is virtually identical to that of those practicing in rural areas. Other results reported in Table 1 suggest that physicians in solo practice have higher mean debt than those in other practice modalities.

In relation to specialty, the highest average debt was incurred by those currently practicing in psychiatry, obstetrics/gynecology or general/family practice. One reason that those in these specialties have higher debt may be that they on average graduated from medical school in more recent years than those in the sample who specialized in areas such as surgery, radiology, or anesthesiology. Those who attended medical school in more recent years accumulated more debt at least in part because the cost of medical education has been increasing over time. Analysis suggests that this has a small effect on the differences noted in Table 1; for instance, only around 15 percent of the $2,100 difference in mean debt between general/family practitioners and surgeons in Table 1 results from varying graduation years. Thus, even taking this factor into account, these patterns of indebtedness seem to suggest that those with high debt do not choose more remunerative specialties.

Similar conclusions may be drawn from Table 2, which presents the distribution of physicians across career decisions for different debt levels. With this table, the choices of those with relatively high debt can be compared with those incurring little debt. For instance, 6.5 percent of those with $40,000 or more medical education debt practice in the New England area whereas 5.8 percent of those with debt of $1 to $9,999 practice in this census division. Relative to those with the lowest amount of debt, physicians with the highest level of debt:

- have a similar geographic distribution except that they more frequently locate in the Pacific region and in rural areas;

- are more often in solo practice and less often in group practice; and

- more frequently choose specialties of psychiatry and obstetrics/gynecology and less frequently choose internal medicine and pediatrics.

These variations in behavior are quite small, however. In particular, only three distributions noted in Table 2 are significantly different at the .05 level from the distribution of all physicians: the dis-

Table 2

1983 Career Decisions of Resident Physicians Surveyed in 1979 by Level of Debt

	DEBT LEVEL					ALL PHYSICIANS IN SAMPLE
	$1 - $9,999	$10,000- $19,999	$20,000- $29,999	$30,000- $39,999	$40,000+	
NUMBER OF PHYSICIANS (% OF SAMPLE)	790 (27%)	643 (22%)	272 (9%)	105 (4%)	64 (2%)	2941 (100%)
% IN GIVEN DEBT LEVEL BY:						
Census Region						
New England	5.8%	7.8%	5.6%	8.8%	6.5%	6.7%
Middle Atlantic	13.2	15.4	14.9	15.7	14.5	15.5
East North Central	14.1	15.1	13.1	13.7	6.5	14.4
West North Central	8.4	7.2	10.1	9.8	9.7	7.6
South Atlantic	18.2	16.2	16.0	20.6	14.5	17.5
East South Central	5.8	6.1	6.0	3.0	4.8	5.2
West South Central	10.5	8.3	6.3	6.9	4.8	9.4
Mountain	6.3	6.8	5.2	7.8	9.7	6.3
Pacific	17.5	17.0	22.8	13.7	29.0	17.4
	100.0	100.0	100.0	100.0	100.0	100.0
Practice Location						
Urban	81.6	80.9	82.8	81.3	77.4	83.3
Rural	18.4	19.1	17.2	18.7	22.6	16.7
	100.0	100.0	100.0	100.0	100.0	100.0
Practice Modality						
Solo	18.1	19.3	20.2	34.1	42.0	20.5
Partnership	8.5	9.1	12.3	11.8	12.0	9.5
Arrangement Non-Group	6.6	5.3	5.9	4.7	2.0	5.2
Group	26.6	28.5	25.6	20.0	10.0	24.2
Hospital-Based	31.7	29.7	26.1	20.0	26.0	31.9
Medical School	8.5	8.1	9.9	9.4	8.0	8.5
	100.0	100.0	100.0	100.0	100.0	100.0
Specialty						
General/Family Practice	13.6	14.4	18.5	22.1	15.9	13.3
Internal Medicine	22.3	23.9	28.1	25.0	15.9	23.4
Surgery	19.6	19.5	18.5	15.4	17.4	20.3
Pediatrics	8.8	8.3	4.1	8.7	3.2	6.9
Obstetrics/Gynecology	5.7	8.6	4.4	8.7	14.3	6.6
Radiology	5.5	4.4	5.6	1.9	6.3	5.7
Psychiatry	6.4	5.8	4.4	10.6	11.1	7.1
Anesthesiology	3.2	3.8	4.8	1.0	3.2	3.8
Other	14.9	11.3	11.5	6.7	12.7	12.8
	100.0	100.0	100.0	100.0	100.0	100.0

Source: 1979 Survey of Resident Physicians and 1983 AMA Physician Masterfile.

tributions by practice modality for the debt levels of $30,000 - $39,999 and $40,000+, and the distribution by specialty for the debt level of $30,000 - $39,999. Thus, contrary to the beliefs of many, physicians with the highest level of debt do not appear to choose more remunerative practice locations, modalities, and specialties.

1983 Survey of Resident Physicians

The 1983 Survey of Resident Physicians represents another source of information for examining the effect of indebtedness on career decisions. This survey provides the most up-to-date information on educational indebtedness and career plans of physicians-in-training. The survey contains questions not only in these areas but also on choice of residency program, working conditions, and personal background. Over 13,000 resident physicians and fellows were sent questionnaires. Completed surveys were obtained from 45 percent of the sample.

Tables 3 and 4 report information on the relationship between indebtedness and career decisions from the 1983 Survey. These tables are comparable to Tables 1 and 2, respectively. It is important to recognize, however, that Tables 3 and 4 report preferences for future practice location, modality, and specialty rather than actual choices as reported in Tables 1 and 2.

Table 3 reports the percent of resident physicians and fellows who incurred medical education debt and the average debt levels for those individuals who had debt. Thus, in 1983, 65.1 percent of resident physicians and fellows had some indebtedness attributable to medical education, with a mean debt of $18,200. In comparison to 1979, then, the average amount of debt has increased by around $5,000. In real (i.e., inflation adjusted) terms, this represents about a 3 percent increase in indebtedness, suggesting that debt loads have indeed increased over time.

Other data from the 1983 Survey that are not reported in Table 3 demonstrate the rapid growth in indebtedness over time. For resident physicians in the first year of graduate medical training, the mean level of debt was $21,600. Comparable figures for those in later years of training are: $18,900 for those in the second year, $17,000 for the third year, $15,400 for the fourth year, and $12,500 for those in the fifth and subsequent years of training. Thus, average indebtedness of new physicians appears to be increasing by around $2,000 a year.

From Table 3, there appears to be little variation in the percentage with debt and mean debt levels by various categories. Those planning to practice in urban areas have virtually the same average level of indebtedness as those planning to practice in rural areas. In

Table 3

Percent of Resident Physicians With Medical Education Debt and Mean Debt by Practice Location, Modality, and Specialty Preferences

	% WITH MEDICAL EDUCATION DEBT	MEAN DEBT OF THOSE WITH SOME DEBT
TOTAL	65.1%	$18,200
Practice Location Preference		
Urban	65.7	18,100
Rural	67.5	18,200
Practice Modality Preference*		
Solo	61.7	18,400
Group Fee-For-Service	71.3	18,700
Prepaid Group	69.5	18,800
Hospital-Based	60.0	19,200
Medical School	60.9	17,100
Research	61.1	14,600
Armed Forces	46.8	9,800
Other	67.1	15,800
Specialty		
General/Family Practice	73.1	19,300
Internal Medicine	62.5	18,000
Surgery	63.2	17,600
Pediatrics	62.0	18,500
Obstetrics/Gynecology	73.0	16,900
Radiology	67.0	17,800
Psychiatry	57.4	19,100
Anesthesiology	72.5	19,300
Other	64.2	18,400

Source: 1983 Survey of Resident Physicians

*Means within category significantly different at .05 level.

relation to practice modality, resident physicians planning to go into research and the armed forces have the lowest mean level of indebtedness. In addition, the highest average debt load is incurred by those expecting to enter general/family practice, anesthesiology, and psychiatry.

As noted for Table 1, variations in debt level by specialty can partially be explained by the more recent graduation years of those planning to go into general/family practice. Analysis suggests that this has a minimal impact on the patterns of indebtedness shown in Table 3. Thus, the data presented in the table suggest that those planning to practice in higher paying specialties do not have more debt on average than those with different career plans.

Table 4 reports the distribution of resident physicians and fellows across career preferences for different levels of medical education debt. This table allows examination of whether those with higher debt act differently when formulating career plans than those with lower debt. It is comparable to Table 2, which reports information from the 1979 Survey. In 1983, those with relatively large debt loads ($40,000+) represent 4 percent of the total number of physicians in the sample. Though this proportion is twice as large as that obtained from the 1979 Survey, it still represents only a small portion of resident physicians.

Those with relatively high debt do not appear to have significantly different career plans than those with low debt, as demonstrated in Table 4.

- Preferences for urban or rural practices are quite similar across all levels of indebtedness.

- Slightly more resident physicians with high debt expect to go into group fee-for-service practices than those with lower debt.

- A slightly larger proportion of those with high debt plan to enter general/family practice, psychiatry, and anesthesiology.

These variations are very small, however. The patterns of indebtedness reported in Table 4 then do not suggest that those with higher debt will more frequently choose higher paying practice locations, employment modalities, or specialties.

CONCLUSIONS

The three-part research program developed by the AMA has examined the relationship of indebtedness and career plans at various points of

Table 4

Career Decisions of Resident Physicians by Level of Debt

	DEBT LEVEL					ALL PHYSICIANS IN SAMPLE
	$1 - $9,999	$10,000- $19,999	$20,000- $29,999	$30,000- $39,999	$40,000+	
NUMBER OF PHYSICIANS (% OF SAMPLE)	870 (15%)	1465 (25%)	891 (15%)	356 (6%)	251 (4%)	5884 (100%)
Practice Location Preference						
Urban	79.2%	78.2%	76.7%	80.5%	78.7%	78.8%
Rural	20.8	21.8	23.3	19.5	21.3	21.2
	100.0	100.0	100.0	100.0	100.0	100.0
Practice Modality Preference*						
Solo	12.6	12.2	11.8	11.7	15.5	13.2
Group Fee-for-Service	45.0	57.0	53.3	59.9	54.0	49.2
Prepaid Group	2.7	2.3	4.9	3.3	2.0	2.9
Hospital-Based	8.8	9.7	13.2	10.0	11.5	11.5
Medical School	12.3	11.1	12.3	9.4	9.5	12.3
Research	.9	.8	.4	.3	.5	.7
Armed Forces	11.5	2.2	1.4	1.3	3.0	5.8
Other	6.2	4.7	2.7	4.0	4.0	4.4
	100.0	100.0	100.0	100.0	100.0	100.0
Specialty						
General/Family Practice	11.4	14.1	14.4	14.6	15.5	12.2
Internal Medicine	22.1	23.2	21.1	18.0	20.7	22.7
Surgery	23.9	21.4	21.2	23.9	19.9	22.8
Pediatrics	6.8	5.8	8.1	9.3	4.8	7.1
Obstetrics/ Gynecology	8.2	6.9	5.6	5.1	5.6	5.9
Radiology	5.1	5.2	6.3	5.6	4.4	5.3
Psychiatry	5.4	4.6	5.8	6.2	7.1	6.1
Anesthesiology	4.7	4.7	5.4	6.2	6.0	4.6
Other	12.5	14.1	12.1	11.2	15.9	13.3
	100.0	100.0	100.0	100.0	100.0	100.0

Source: 1983 Survey of Resident Physicians.

*Distributions significantly different at .05 level from distribution of all physicians, except for debt level of $40,000+.

the career development of new physicians. The career plans of graduating medical students were examined initially. Another phase dealt with resident physicians who have made some but not all decisions about their medical careers. Finally, data on those who have completed training and have begun practicing medicine were analyzed. Similar findings were obtained in each phase of the project: no clear relationship between debt and career choices appears to be present.

More detailed analysis is necessary in order to reach firm conclusions on indebtedness and career decisions. In particular, it is necessary to examine how various personal and economic characteristics of physicians interact in the formulation of career decisions in order to isolate the effect of indebtedness. This type of analysis is currently taking place. The results of this research will be disseminated in the professional literature, as appropriate.

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Korcok, Milan, "Medical Education: Prosperitas Interrupta," Journal of the American Medical Association 249(1), January 7, 1983, pp. 12-16.

Dr. SUNDWALL. Thanks very much, Dr. Nelson. Mr. Terrell, let's go ahead with your testimony.

Mr. TERRELL. I am Charles Terrell, assistant dean for student affairs at the Boston University School of Medicine. I am testifying today on behalf of Boston University and the Association of American Medical Colleges. I am being accompanied today by Dr. John F. Sherman, vice-president of AAMC.

Given time limits, I will restrict my comments to a synopsis of the association's key concerns. However, I would like to request that the more lengthy explanation of the AAMC position, to be submitted shortly, be entered into the hearing record.

Dr. SUNDWALL. Without objection, that will be done.

Mr. TERRELL. Twenty years ago, with the passage of the first Health Professions Educational Assistance Act of 1963, Public Law 88-129, the Nation's medical schools joined with the Federal Government in a partnership dedicated to solve complex national health manpower problems that neither could solve alone.

The relationship has been mutually profitable. The capacity of the educational system has been more than doubled, thereby averting an imminent national shortage of physicians. This expansion, combined with increased educational emphasis on primary care specialties in residency training programs, has begun to improve substantially the prevailing geographic and specialty maldistribution of physicians. Student financial assistance programs have enhanced the access of the economically disadvantaged to medical education, despite the steep rise in the costs of the latter. Finally, many educational programs targeted on the emerging problems of our times, such as the aging of the population, have been initiated.

In spite of progress to date, the task is far from completed, and extension of current statutory authorities to continue the effort that has been so auspiciously launched is highly desirable. Your legislation is a suitable vehicle for this purpose; the specific recommendations of the AAMC on time and dollar limits for the various authorities are attached.

A number of important programs authorized under the act have been underfunded for several years and we urge that this be taken into account as you consider authorization ceilings for them. These ceilings should be high enough to give appropriators the room they will need to fund the programs at levels consistent with future national needs.

First, student financial assistance. The AAMC has long held that, to the extent possible, medical students with family contributions should pay for their own education either out of pocket or by borrowing. On the other hand, many medical schools have adopted, and most would like to adopt, a "needs-blind" admission policy, that is, to accept the most promising applicants, irrespective of their ability to pay. Since a major Federal objective has also been to expand educational opportunity for the economically disadvantaged, the goals of academic institutions and the Government are, fortuitously, completely congruent.

Student aid has become increasingly necessary as the costs of medical education have risen over the last two decades. Of the students who received M.D.'s in 1983, 86 percent reported indebtedness, averaging $26,347. Thus, it is clear that few students can totally fund their education out of their own or their families' resources. Federal programs have been crucially important in filling the gap.

Exceptional financial need scholarships enable students with severely limited resources to finance the first year of their medical education. Economically underprivileged students, however talented, are almost uniformly unwilling to incur indebtedness when they are uncertain about their ability to survive the rigors of the educational program. The EFN scholarship allows a financially risk free first year, after which successful students—the overwhelming majority—are willing to negotiate loans for their subsequent educational expenses.

In its 1985 budget documents the administration recommends that the EFN program be replaced with a loan program for disadvantaged students, such as those that have heretofore benefited from the EFN scholarships. We welcome the administration's proposal, but we ask that the authorizing committee provide that such additional loan assistance be available as a complement to the EFN scholarships, which are so important to needy first-year students, rather than as a replacement for them.

The health professions student loan programs is a Government-capitalized, needs-based, campus-administered, low-cost loan program for needy medical students, with the repayment terms attuned to the earning patterns of young doctors. Repayments flow into the student loan fund in the school from which the student borrowed, and immediately become available for relending. The HPSL program is especially effective because it is campus-administered and thus extremely flexible to the needs of students.

Recent revelations that a significant number of physicians who received these Government-subsidized awards were in arrears in repayment has besmirched the program in the eyes of many, but the prompt and effective response of the schools to reduce delinquency has gone a long way to restoring confidence in it. Statutory modifications to further enhance loan collection procedures and thereby reduce the delinquency and default rates of the HPSL program are worth consideration. Most schools badly need additional capitalization of their revolving funds. We hope the bill will reflect this as it is marked up.

The Health Educational Assistance Loan Program provides a Federal guarantee for private sector loans to medical students The allowable interest rate for these loans is a hefty 3.5 percent above market rates—91-day Treasury bills. The statute sets limits on the aggregate annual amount of borrowing that the Government will insure. In recent years, as costs of education have risen, and the more inexpensive assistance programs have become less available, medical student borrowing under this program has escalated sharply. The current authorization level of $250 million should be increased to reflect growing HEAL demand. This program does not require Federal outlays.

The AAMC strongly endorses the extension for an additional 5 years of the authorities for each of these programs.

Next, institutional assistance. In the 10 to 15 years after enactment of Public Law 88-129, Federal programs emphasized assistance not only to medical students but also to the institutions responsible for educating physicians. The last remaining authority of that category is for the construction of health teaching facilities.

While this program has not been funded since fiscal year 1978, the inescapable reality is that many of the facilities built in the early days of the program are reaching an age when remodeling, renovating and reequipping will be necessary to maintain excellence in medical education through changes in programs in light of advances in biomedical science and medical practice.

The AAMC believes Federal matching assistance for such undertakings is justifiable. This authority should be extended and spending under it should resume at the earliest possible moment.

Finally, targeted educational initiatives. Over the more than 2 decades during which health manpower legislation has been on the books, the focus and emphasis of the targeted initiatives have changed as events have unfolded. Several of those programs warrant explicit attention today.

Federal financial assistance has been absolutely critical to the successful efforts of schools of medicine to reverse increasing subspecialization. The antidote has been to make more attractive the training programs in primary care—family medicine, general internal medicine, and general pediatrics. But these primary care educational programs must be sustained over a long period to be effective and Federal assistance is indispensable. This is why these initiatives must continue.

Grants for research and development on information management and computer technology in medical service could yield very large returns. This technology really holds enormous potential not only for facilitating the handling of the huge volumes of technical information that individual medical students and physicians must manage, but also for improving the effectiveness of the diagnosis and treatment of disease. This authority has currently expired, but we urge that it be reauthorized.

Four decades of achievements in medical research have significantly extended lifespans and, when coupled with other factors, have resulted in a sharp expansion in the fraction of elderly in our society. The Federal Government's interest in this area is obvious, since under the medicare program it bears the major share of responsibility for funding the medical care of the elderly. Funding of grants to expand and improve geriatric education would clearly be in the public interest.

From a host of societal perspectives, Federal investments in these targeted programs would be highly productive.

Several other provisions also warrant extension, including the financial distress grants, the disadvantaged assistance program, the preventive residency training programs, and the area health education initiative.

As an example of just how effective programs financed by the Federal Government can be, I would like to take the opportunity to draw the committee's attention to the work being done at the Boston University School of Medicine. Disadvantaged assistance funds have enabled us to establish exceptional programs for disadvantaged students, particularly minorities. Our AHEC has been a leader for creative programs within Boston's inner city. I would like to submit descriptions of these programs for the record.

This has been an all-too-brief summary of the views of the association on this very important bill. We would be pleased to try to answer any questions or clarify any positions.

Once again, thank you for allowing the association to comment on this important bill.

[The prepared statement of Mr. Terrell, the programs description, and response to questions submitted by Senator Hatch follow:]

association of american
medical colleges

Testimony of the

Association of American Medical Colleges

on

"The Health Professions Training Assistance Act of 1984"

Mr. Chairman and Members of the Committee, the Association of American Medical Colleges (AAMC) appreciates this opportunity to share its views on "The Health Professions Training Assistance Act of 1984." Given time limits, I will restrict my comments to a synopsis of the Association's key concerns. However, I would like to request that the more lengthy explication of the AAMC's position, to be submitted shortly, be entered into the hearing record.

Twenty years ago, with passage of the first Health Professions Educational Assistance Act of 1963 (PL88-129), the nation's medical schools joined with the Federal government in a partnership dedicated to solve complex national health manpower problems that neither could solve alone. The relationship has been

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Presented before the Senate Committee on Labor and Human Resources, March 14, 1984, by Charles Terrell, Assistant Dean for Student Affairs, Boston University School of Medicine, Boston, Massachussetts.

mutually profitable. The capacity of the educational system has been more than doubled, thereby averting an imminent national shortage of physicians. This expansion, combined with increased educational emphasis on primary care specialties in residency training programs, has begun to improve substantially the prevailing geographic and specialty maldistribution of physicians. Student financial assistance programs have enhanced the access of the economically disadvantaged to medical education, despite the steep rise in the costs of the latter. Finally, many educational programs targeted on the emerging problems of our times, such as the aging of the population, have been initiated.

In spite of progress to date, the task is far from completed, and extension of current statutory authorities to continue the effort that has been so auspiciously launched is highly desirable. Your legislation is a suitable vehicle for this purpose; the specific recommendations of the AAMC on time and dollar limits for the various authorities are attached.

A number of important programs authorized under the Act have been underfunded for several years and we urge that this be taken into account as you consider authorization ceilings for them.

First, Student Financial Assistance

The AAMC has long held that, to the extent possible, medical students, with familial contributions, should pay for their own education, either out of pocket or by borrowing. On the other hand, many medical schools have adopted, and most would like to adopt, a "needs blind" admission policy, i.e., to accept the most promising applicants, irrespective of their ability to pay. Since a major Federal objective has also been to expand educational opportunity for the economically disadvantaged, the goals of academic institutions and the government are, fortuitously, completely congruent.

Student aid has become increasingly necessary as the costs of medical education have risen over the last two decades. Of the students who received M.D.s in 1983, 86% reported indebtedness, averaging $26,347. Thus, it is clear that few students can totally fund their education out of their own or their families' resources. Federal programs have been crucially important in filling the gap.

Exceptional Financial Need (EFN) Scholarships enable students with severely limited resources to finance the first year of their medical education. Economically underprivileged students, however talented, are almost uniformly unwilling to incur indebtedness when they are uncertain about their ability to survive the rigors of the educational program. The EFN scholarship allows a financially risk free first year, after which successful students---the overwhelming majority---are willing to negotiate loans for their subsequent educational expenses.

In its 1985 Budget Documents the Administration recommends that the EFN Program be replaced with a loan program for disadvantaged students, such as those that have heretofore benefited from the EFN scholarships. We welcome the Administration's proposal, but we ask that the Authorizing Committee provide that such additional loan assistance be available as a complement to the EFN scholarships, which are so important to needy first year students, rather than as a replacement for them.

The Health Professions Student Loan (HPSL) program is a government capitalized, needs-based, campus-administered, low cost loan program for needy medical students, with the repayment terms attuned to the earning patterns of young doctors. Repayments flow into the student loan fund in the school from which the student borrowed, and immediately become available for relending. The HPSL program is especially effective because it is campus administered and thus extremely flexible to the needs of students.

Recent revelations that a significant number of physicians who received these government subsidized awards were in arrears in repayment has besmirched the program in the eyes of many, but the prompt and effective response of the schools to reduce delinquency has gone a long way to restoring confidence in it. Statutory modifications to further enhance loan collection procedures and thereby reduce the delinquency and default rates of the HPSL program are worth consideration. Most schools badly need additional capitalization of their revolving funds; we hope the bill will reflect this as it is marked up.

The Health Educational Assistance Loan (HEAL) program provides a Federal guarantee for private sector loans to medical students. The allowable interest rate for these loans is a hefty 3.5% above market rates (91-day Treasury bills). The statute sets limits on the aggregate annual amount of borrowing that the government will insure. In recent years, as costs of education have risen, and the more inexpensive assistance programs have become less available, medical student borrowing under this program has escalated sharply. The current authorization level of $250 million should be increased to reflect growing HEAL demand. This program does not require Federal outlays.

The AAMC strongly endorses the extension for an additional five years of the authorities for each of these programs.

Next, Institutional Assistance

In the 10-15 years after enactment of P.L. 88-129, Federal programs emphasized assistance not only to medical students but also to the institutions responsible for educating physicians. The last remaining authority of that category is for the construction of health teaching facilities.

Health Educational Facilities Construction provisions in the statute (Part B, Sections 720-726) authorize matching grants and loan guarantees with interest subsidies for the construction, expansion, and remodeling of teaching facilities at medical schools. While this program has not been funded since FY 1978, the inescapable reality is that many of the facilities built in the early days of the program are reaching an age when remodeling, renovating and reequipping will be necessary to maintain excellence in medical education through changes in programs in light of advances in biomedical science and medical practice. The AAMC believes Federal matching assistance for such undertakings is justifiable.

This authority should be extended and spending under it should resume at the earliest possible moment.

Finally, Targeted Educational Initiatives

Over the more than two decades during which health manpower legislation has been on the books, the focus and emphasis of the targeted initiatives have changed as events have unfolded. Several of those programs warrant explicit attention today.

Federal financial assistance (Sections 780, 786 and 784) has been absolutely critical to the successful efforts of schools of medicine to reverse increasing subspecialization. The antidote has been to make more attractive the training programs in primary care---family medicine, general internal medicine and general pediatrics. But these primary care educational programs must be sustained over a long period to be effective and Federal assistance is indispensible.

Grants for Research and Development on Information Management and Computer Technology (Section 769A) in medical service could yield very large returns. This technology really holds enormous potential not only for facilitating the handling of the huge volumes of technical information that individual medical students and physicians must manage, but also for improving the effectiveness of the diagnosis and treatment of disease. This authority has currently expired but we urge that it be reauthorized.

Four decades of achievements in medical research have significantly extended life-spans and, when coupled with other factors, have resulted in a sharp expansion in the fraction of elderly in our society. The demographic realities of the present and future make it imperative for medical educators to intensify their focus on the care of aging population. The Federal government's interest in this area is obvious, since under the Medicare program it bears the major share of responsibility for funding the medical care of the elderly. Funding of grants to expand and improve Geriatric Education (Section 788(d)) would clearly be in the public interest.

From a host of societal perspectives, Federal investments in these targeted programs would be highly productive.

Several other provisions also warrant extension, including the Financial Distress Grants (Section 788 A&B), the Disadvantaged Assistance Program (Section 787), the Preventive Residency Training Programs (Section 793) and the Area Health Education initiative (Section 781).

As an example of just how effective programs financed by the Federal Government can be, I would like to take the opportunity to draw the Committee's attention to the work being done at the Boston University School of Medicine. Disadvantaged Assistance Funds have enabled us to establish exceptional programs for disadvantaged students, particularly minorities. Our AHEC has been a leader for creative programs within Boston's inner city. I would like to submit descriptions of these programs for the record.

This has been an all too brief summary of the views of the Associaton on this very important bill. I would be happy to try to answer any questions that you may have. Once again, thank you for allowing the Association to comment on this important bill.

The AAMC makes the following recommendations for programs authorized under the Health Professions Education Assistance Act:

Student Financial Assistance

1. The Scholarship for First-Year Students of Exceptional Financial Need (EFN) Program, Sec. 758 of Title VII, should be renewed. The authorization levels should allow for sufficient funding to enable five students to be supported in each school. The cost for medical schools, based on 1983-84 academic year data, would be approximately $8 million for the first year.

2. The authority for the Health Professions Student Loan (HPSL) program in Sec. 742 should be extended for five years with funding ceilings for new Federal Capital Contribution set at $20 million per year.

3. Separate funding for loan repayment, in return for completion of work in health manpower shortage area as described in Sec. 741(f), should be authorized under the HPSL program at ceilings of $1, $2, $3, $4, and $5 million over the next five years.

4. The penalty assessed to late payers of HPSLoans (Sec. 741(j)) should be increased to an amount not to exceed 6% of payments overdue by 60 days or more.

5. The authority for the Health Education Assistance Loan (HEAL) Program should be extended, with the ceilings for the amount of borrowing that the Federal Government will guarantee (as outlined in Sec. 728) increased to $275, $300, $325, $350, and $375 million for FYs 1985-1989.

6. The statutory provisions (Sec. 728(c)) to consolidate HEALoans should be retained in the expectation that the basic authority for this process in Sec. 439(o) of Part B of Title IV of the HEA of 1965 will be reenacted.

Institutional Support

7. The authorities for financial distress grants and advanced financial distress assistance, outlined in Sec. 788A and 788B, should be extended with a funding ceiling of $10 million each for FYs 1985-1989.

8. The authorities for construction, in Part B of Title VII, should be extended with a modest funding ceiling of $25 million over the next five years.

Special Health Professions Education Projects

9. The authority for grants to provide family medicine residency and training programs, outlined in Sec. 786, should be renewed with a funding ceiling of $40 million for each year from FY 1985 through FY 1989.

10. The programs for support of Departments of Family Medicine, Sec. 780, should be reauthorized at $15 million each year from FY 1985 through FY 1989.

11. The grants for training, traineeships and fellowships in general internal medicine and pediatrics should be renewed with authorization ceilings of $20 million for each of the next five years.

12. The grant program to support residency training in preventive medicine should be renewed for the next five years, with authorization ceilings increasing from $3 to $5 million over that interval.

13. The educational assistance program for disadvantaged individuals should be extended for the next five years with a funding ceiling of $30 million for FY 1985, increasing $2 million each year through FY 1989.

14. The discretionary grant authority, outlined in Sec. 788(b), for projects established to address specific needs of the health professions should be renewed for five years at $10 million per year.

15. The authority for grants for computer technology health care demonstration programs, as described in Sec. 769A, should be extended and a funding ceiling of $15 million be set for FYs 1985-1989.

16. The grant program for support services to health professionals practicing in health manpower shortage areas, authorized in Sec. 788(c)(1), should be renewed for five years at $5 million per year.

17. The authority for projects to establish or expand educational programs in geriatric medicine (Sec. 788(d)(1))should be extended for five years with a funding ceiling of $25 million per year.

18. The Administration's proposal to create a new loan program for the disadvantaged should be supported as a supplement to the other existing student financial assistance programs, at a level of $10 million per year for the next 5 years.

BOSTON AREA HEALTH EDUCATION CENTER

1839

1864

A Program Sponsored By
Boston University School of Medicine
In Partnership With The Boston
Department of Health and Hospitals

FOREWORD

During the past two decades, issues surrounding health care delivery and services rose to prominence in the consciousness of the nation. The belief that health care was a right spurred a new ideology which sought legislative reforms at the Federal level to create a health care delivery system which was responsive, comprehensive, coordinated and accessible to all Americans. However, it became apparent that accessible care was dependent on many factors including accessible health professional manpower and facilities. Indeed, one of the major impediments to the development of such a system was the overwhelming geographic and specialty maldistribution of physicians and other health professionals. In 1970, the Carnegie Commission issued a study titled "Higher Education and the Nation's Health." This report placed the burden of quality health care services on institutions of higher education and recommended steps to address the key health manpower problems which ultimately affect health care delivery. The Area Health Education Center concept grew out of these recommendations and Federal support for this initiative began in 1971 and led to the funding of several AHECs across the United States.

AHEC programs are funded for a period of six years by the U.S. Department of Health and Human Services Bureau of Health Manpower. Each AHEC program has two components: a medical school representing an academic health science center and an AHEC which is located in a medically underserved area. The mandate of each program is essentially to respond to the geographic and specialty maldistribution of professional health manpower in medically underserved areas within its region. The goal of the AHEC program is to utilize a range of educational incentives to recruit and stabilize health manpower working in primary care centers and to develop innovative training programs and field experiences for students of the various health professions. To achieve this goal it is necessary for the two components to work as partners, creating and implementing programs which enhance the work of primary care professionals practicing in medically underserved areas and direct students of the health professions towards careers in primary care and community practice.

The Boston Area Health Education Center program is one of six regional AHECs which make up the Massachusetts State-wide AHEC program. The University of Massachusetts Medical Center (UMMC) is the prime contractor for this state-wide program. UMMC subcontracts with Boston University School of Medicine as the health science center of the Boston program. Boston University then subcontracts with the Trustees of Health and Hospitals for the continued support and development of the Boston AHEC which is located at Boston City Hospital.

Boston University School of Medicine is represented by the Office of the Program Director which is located at the Boston University Medical Center. This office is responsible for making available to the BAHEC the resources of the University and acting as a facilitator in the development of programs for health professionals and students of the health professions.

The Office of the Boston AHEC, located at Boston City Hospital, works in close collaboration with health professionals at Boston City Hospital and Boston's 26 neighborhood health centers. Boston City Hospital is a 462 bed teaching hospital affiliated with Boston University School of Medicine. B.C.H. has the most active emergency service in the city and a major new Ambulatory Care Center which opened in 1977. The Division of Community Health Services provides city-wide public health and primary care services through neighborhood health centers and in schools and homes. The Division also operates the city-wide ambulance and paramedic system, as well as all emergency and ambulatory care at Boston City Hospital and is responsible for all relationships with neighborhood health centers. At present there are six neighborhood health centers closely affiliated with the department of Health and Hospitals; these are incorporated as the Affiliated Neighborhood Health Centers, Inc. to which direct cash grants are given. There are an additional 13 health centers funded by the Department under its matching grant program. These health centers have other hospitals as their principal back-up institutions, and the Department essentially matches the cash or in-kind donation from these hospitals. Finally, there are three health centers to whom the Department donates in-kind staff or other services.

The Boston AHEC has developed an Advisory Committee which serves as the mechanism by which health personnel, community agencies and consumers advise the BAHEC Director on policy decision, establishment of priorities and recommendations in program planning and development. The board consists of members representing a broad spectrum of health professionals, academicians and community individuals. Through this mechanism, BAHEC provides a forum for individuals working to achieve a common goal.

Together these consumers, health professionals and health professions educators attempt to develop and implement programs in three primary areas: health professions education, continuing education, and recruitment of minority/disadvantaged students into the health professions.

The following pages describe the purpose, goals and programs of the Boston AHEC as it begins its fifth contract year.

INTRODUCTION

The AHEC program in Boston began based on the knowledge that the urban poor and near poor, like their rural counterparts, are victims of the same geographic and specialty maldistribution of the health professions which initiated the original AHEC legislation. Although the miles which separate the medically underserved from health services are not as great in urban areas as in rural, there are other barriers which are as difficult to cross in a city as a 200 mile journey in the country. The city of Boston is regarded by much of the nation as a "medical mecca." People from around the country and from other nations travel hundreds of miles to receive care in any one of the 54 acute care hospitals which are in and around the city. Yet, for many of the citizens of Boston, health care providers are not available even in the neighborhood.

Of the 16 distinct neighborhoods of Boston, eight have been Federally designated as medically underserved and seven have been Federally designated as physician shortage areas. In one area of Boston which has a population of 36,000, there is not one single primary care practitioner. Those professionals who do practice in the community are for the most part associated with the 26 neighborhood health centers scattered throughout the city. Yet, despite the commitment of these health centers and the professionals they employ, there is a high turn-over rate. A recent study found that 61% of NHC physicians stayed on staff for no more than two and a half years. Additionally, 65% of the mid-level practitioners (nurse practitioners and physician assistants), 67% of the registered nurses and 64% of the social work/mental health providers also stayed on staff for no more than two and a half years.

This turn-over rate can be attributed to a number of factors, not the least of which may be a pronounced feeling of professional isolation from the academic health community. This isolation is perpetuated by many members of the academic community who perceive community practice as being less than "first rate" medicine. This attitude is passed on, often quite subtly, to the students they teach, thus creating a system which propagates tertiary, specialty practice by rewards of status and prestige. It is therefore essential that students of the health professions participate in clinical experiences which expose them to quality primary care such as is found in the neighborhood health centers of Boston.

Significantly, it is not only students of the health professions who must be exposed to primary health care at the community level but also their instructors. By including community physicians in the training of medical and other students, academic faculty can share and gain information and knowledge from their colleagues practicing in the community. Further, through continuing education programs, the resources of the academic community can be shared with Boston's primary care providers. Although Boston has many health professions schools, the continuing education programs offered by them have been focused on topics which relate to specialty and hospital practice. Rarely do these programs relate specifically to people at primary care sites, and often the cost for these programs is quite high, making regular attendance prohibitive to a health center professional working for lower pay and unable to obtain reimbursement. These programs are also held at the schools and institutions which sponsor them, therefore heightening the inaccessibility of these programs to community-based providers. This situation only furthers the isolation of these professionals and makes primary care/community practice much less attractive.

Boston is not only medically underserved as a whole, but its minority populations are grossly underrepresented in the health professions. In all of Massachusetts, no licensed health profession, including medicine, dentistry, nursing, allied health, optometry, pharmacy and social work, is more than one percent black. Therefore, any program which seeks to address Boston's manpower problem must also address the issues which relate to the recruitment of minority and disadvantaged students into the health professions. From this realization sprang AHEC's recruitment and enrichment program for minority/ disadvantaged high school students interested in pursuing health careers.

Since its inception in 1978, AHEC has made much progress toward meeting its three major goals. The following pages describe they keys to this progress, AHEC's on-going programs.

HEALTH PROFESSIONS EDUCATION

The Boston AHEC has developed educational initiatives for students of the health professions which are innovative and which focus on primary care and community practice. These initiatives reach students at both the undergraduate and graduate levels of their education and include clinical experiences as well as curriculum development.

Medical

As a direct result of BAHEC's involvement, more medical students and primary care residents in pediatrics and medicine are being exposed to the practice of medicine in a community setting. The medical students, through the use of role models and actual rotations at NHCs, are able to compare the practice of medicine within a medical center, a community setting and the neighborhood health center.

For the past two years, third year medical students have been instructed by neighborhood health center physicians in their pediatric and medical clerkships at Boston City Hospital. These NHC physicians obtain faculty appointments from Boston University School of Medicine and teach one session a week at the hospital. This provides the students with an important added dimension to their education. Students are able to acquire skills useful in the practice of primary care in the inner city. Additionally, the community physician is able to emphasize the biopsychosocial aspect of health care and can act as a role model to the student. An equally important aspect of this program is that it provides the opportunity for the health center physician to participate in the education and training of medical students. Such participation is essential to offset the pull toward specialization which is so embedded in medical education.

These same goals are the cornerstone for a third year longitudinal clerkship which the BAHEC has sponsored for the past two years. In this program, third year students may elect a longitudinal primary care rotation at one of three neighborhood health centers. Students spend one afternoon per week for three months at a health center and with combined medicine, pediatric and psychiatric supervision. Instruction is provided by physicians from the center as well as a psychiatrist from the Primary Care Psychiatry Section of BUSM. A holistic or biopsychosocial approach to patient care is emphasized which focuses on understanding the common illnesses and problems of people in the inner city. This experience provides students with a "humanistic" approach to patient care and participation in the delivery of primary care services.

At the graduate level, BAHEC has worked closely with the Primary Care Residency Training Program at BCH. Programs have been developed which introduce residents to many different aspects of health care delivery in an urban setting. In one program, residents provide health care services to students in Boston public schools. The residents work closely with school nurses and with faculty. This longitudinal experience enables them to follow up for a year children and their families, not only from a medical perspective but also from a socio-economic one, since the latter affects and complicates the former. Another program developed by BAHEC is a day care experience for pediatric interns. During this rotation, they have the opportunity to observe and interact with pre-school children in a non-medical setting. The day care experience provides a special opportunity to educate the trainee around cognitive and emotional development as well as to observe how children play and work in the pre-school setting. An objective of BAHEC's residency training programs is to expose residents to the realities of the inner city. In keeping with this objective, BAHEC developed a rotation for first year residents at the Department of Youth Services Group Home. This rotation provides residents with the opportunity to observe the delinquent adolescent in the context and environment of the legal and group home therapeutic systems. Further, it enables residents to observe the end point of earlier childhood maldevelopment so they can take more preventive measures with their younger patients. In addition to these programs, BAHEC has also sponsored a program which allows residents to rotate in two neighborhood health centers in Boston. In this program, primary care residents are exposed to a multidisciplinary approach to health care in a community setting.

Dental

For the past two years, the BAHEC has sponsored a program for fourth year dental students from Boston University Goldman School of Graduate Dentistry. Staff from the School developed a fourth year externship rotation at two neighborhood health centers in Boston. The purpose of the rotation was to increase dental students' awareness of the dental manpower needs and opportunities in urban areas and provide an effective clinical experience in community dentistry.

Nursing

Since it began, BAHEC has been acutely aware of the manpower issues which are unique to the nursing profession. As such a number of initiatives have been developed which seek to address some of those issues through the education of nursing students and practicing nurses.

For the past year, BAHEC, through its Nursing Task Force, has worked with nurse educators to develop an articulation program for nursing schools within Boston. Such a program would provide inner city residents with access to an educational system which allows for a more timely and less stressful move up the career ladder from Licensed Practical Nurse level through Baccalaureate level. As part of this endeavor, BAHEC continues to assist Roxbury Community College in the development and implementation of an Associate Degree in Nursing program. In addition to this program, BAHEC is also collaborating with Boston University School of Nursing in the development of an off-campus part-time baccalaureate program for non-baccalaureate registered nurses. This program will provide nurses the opportunity to participate in a flexible and accessible program.

Social Work

As a result of a two year collaboration between Boston University School of Social Work and the Boston AHEC, a Health Care Concentration was developed and implemented at the School. Prior to the AHEC, the School of Social Work had no concentration which dealt with issues related to social work practice in a health care setting despite the large number of its graduates securing positions in health care settings.

The AHEC Program Director, faculty from the School and community-based health care social workers worked to develop and implement this concentration. This endeavor included a review of all courses at the School and the development of new, health-related curricula. Field work placements were also developed at neighborhood health centers in Boston. This concentration provides students with an opportunity to obtain a firm base of knowledge in the health care delivery system and the needs of its consumers.

Interdisciplinary

Often lacking in the education of health professions students is the opportunity to learn about the role and importance of other health care providers in the care and treatment of patients. Yet, without the opportunity to interact with other disciplines, students tend to view a patient only from their specific professional interest. They rarely learn the ability to view a patient as a whole person who may have a multiplicity of problems. Nor do they gain any experience in working in a health care team. Recognizing this, the AHEC developed and implemented an interdisciplinary clinical rotation for students in medicine, social work, nurse practitionary and pharmacy. This rotation placed students in a clinical setting as part of their own health care team. The clinic session lasted for three hours each week and was followed by a clinical case conference where each student presented the findings from his/her discipline. This program has gained support from each of the schools involved and has added a new dimension in the training of health professions students within Boston University.

CONTINUING EDUCATION

In an effort to stabilize the health manpower force in underserved areas and attract quality health professionals there, the Boston AHEC has developed linkages between NHC providers and the academic community. These linkages include continuing education offerings to encourage professional relationships between health providers, keep them abreast of current medical research, and enhance the professional environment for NHC practice. The AHEC also provides continuing education support to non-NHC community-based providers in order to stabilize their numbers.

BAHEC On-Site Consultation Program

BAHEC, BUSM and the Departments of Medicine and Pediatrics at BCH during Year 02 initiated a program to provide on-site consultation and teaching to NHC provider teams. This effort is designed to offer personalized on-site teaching at NHCs, prevent provider isolation, promote closer BUSM-BCH-NHC ties, and encourage new providers to remain in the city. The program brings BUSM and BCH staff into the community to explain and demonstrate clinical and management techniques and advise providers regarding particular case problems.

School Nurses Program

School nursing is an isolated profession; the nurse has little contact with other nurses and health care providers and limited continuing education opportunities. Developed according to school nurses' expressed needs, BAHEC's continuing education program offers these providers a means of developing collegial relationships in order to increase professional knowledge and skills. This effort involves presentations and supervision at both public and private schools.

Primary Care Nurses Program

Since its third year, BAHEC has sponsored continuing education courses for primary care and NHC nurses. Planned in conjunction with NHC nurses and nurse educators, the program addresses these providers' expressed clinical and career concerns, and confronts urban health care delivery problems.

Community Dentistry Workshop

For the past two years, BAHEC and the BU Goldman School of Graduate Dentistry have sponsored community dentistry workshops for dental personnel at NHCs. Often overlooked by continuing education planners, the needs of these providers must be met to ensure quality dental care and dental staff stability. Developed in conjunction with community dentists, this program brings lecturers on-site to address issues relevant to inner-city dentistry.

Nurse Practitioner Program

Though continuing education has proven to be a valuable tool in stabilizing the health professionals working in NHCs, there have been few continuing education offerings specifically developed for nurse practitioners. Recognizing this problem, the Program Director's Office, BU School of Nursing and a consortium of providers planned a seminar series to address the unmet needs of N.P.s at NHCs. Initiated in Year 04, the program is designed to: provide current information about selected areas of nursing; encourage discussion about issues common to NHCs; and establish a professional network for the attendees.

Social Service and Mental Health Providers Program

Several NHCs employ social service providers having solely undergraduate degrees and desiring additional education. Further, the types of training among graduate social workers is uneven. To meet these providers' continuing education needs, representatives of the Program Director's Office, BU School of Social Work and NHCs planned a seminar/workshop series which began in Year 03. These courses cover a range of clinical and management topics relevant to inner-city practice.

National Health Service Corps

Since AHEC's inception, the Program Director's Office has worked with the New England Regional Office of the National Health Service Corps (NHSC) to identify means of sharing AHEC resources with Corps assignees in the Boston area. Each year, AHEC has helped the NHSC select topics, and has sponsored speakers, for the Corps' Annual Regional Conference in Vermont. Thus AHEC has coordinated the assignees' expressed continuing education needs with its goal of encouraging primary care practice in medically underserved areas.

MINORITY/DISADVANTAGED RECRUITMENT

Boston has a large minority population but minimal minority representation in the health schools and professions. This limited representation in the health system greatly contributes to the difficulties facing inner city residents seeking health services. Recognizing this problem, BAHEC has developed programs to increase the number of qualified minorities and disadvantaged applying to health career educational programs. These future providers are likely to be more sensitive to the needs of the medically underserved than their more privileged peers. Therefore, BAHEC expects that its Minority/Disadvantaged Programs will help increase the number of health professionals practicing in underserved areas.

Career Counseling and Enhancement

This effort began in Year 03, with BAHEC identifying and recruiting minority and disadvanated high school students interested in health careers. The program is essentially a package of academic enrichment and remediation, career education, and college admission/financial aid counseling designed to aid students' acceptance into and completion of health career training programs. In addition, a more career-specific remedial program is offered for minority/disadvantaged students seeking entry into the BCH LPN School. This effort will aid students' acceptance into and completion of the LPN program.

Computer-Assisted Instruction

BAHEC, during Year 04, initiated a computer-assisted instruction program to prepare its students for the increasingly technological worlds of both health professions education and practice. Through becoming computer-literate, the students gain survival skills, which, like reading and writing, will enable their development as health professionals. The program also includes a computer-based SAT simulation program to improve students' standard test results. Higher scores enable the disadvantaged to compete with more privileged students for acceptance into post-secondary health education programs.

CONCLUSION

The Boston Area Health Education Center has initiated a range of programs which seek to establish primary care training in the health professions schools of Boston University, to stabilize the health manpower working in the medically underserved areas of Boston and to recruit minority and disadvantaged students into health professions education. These programs have been innovative both in their approach and in the goals they seek to achieve. The Boston AHEC has, in its five year existence, shown that primary care practice is a viable and desirable health career goal and that the community-based primary care practitioner contributes in a significant way to the health care delivery system of Boston. The BAHEC has also demonstrated that minority/disadvantaged recruitment programs can succeed in preparing high school students for acceptance into health professions schools.

But these programs are just the beginning. There is still much that must be accomplished. As it enters its fifth year, the Boston AHEC Program renews its commitment to the providers, consumers and health professions students in the City of Boston, and to a continuing role in addressing the specialty and maldistribution problems here.

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424-5256

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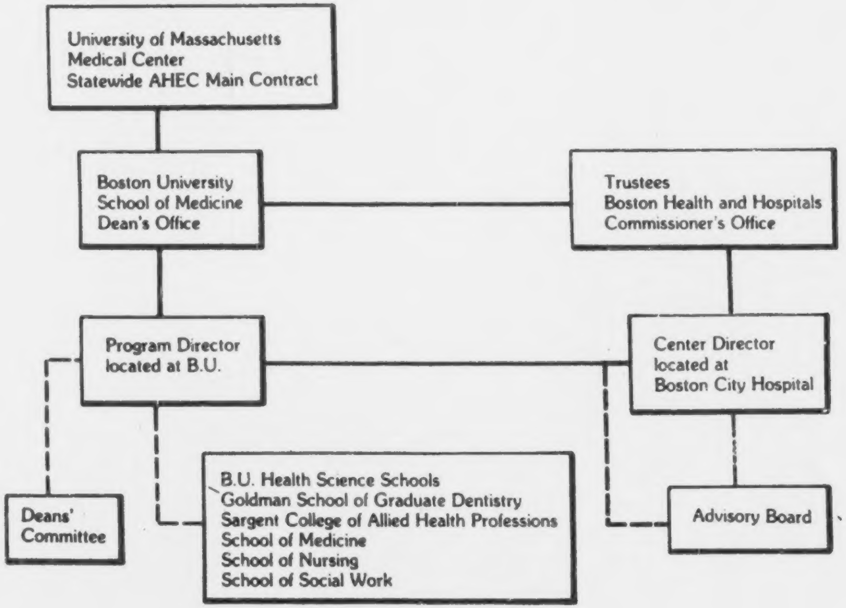
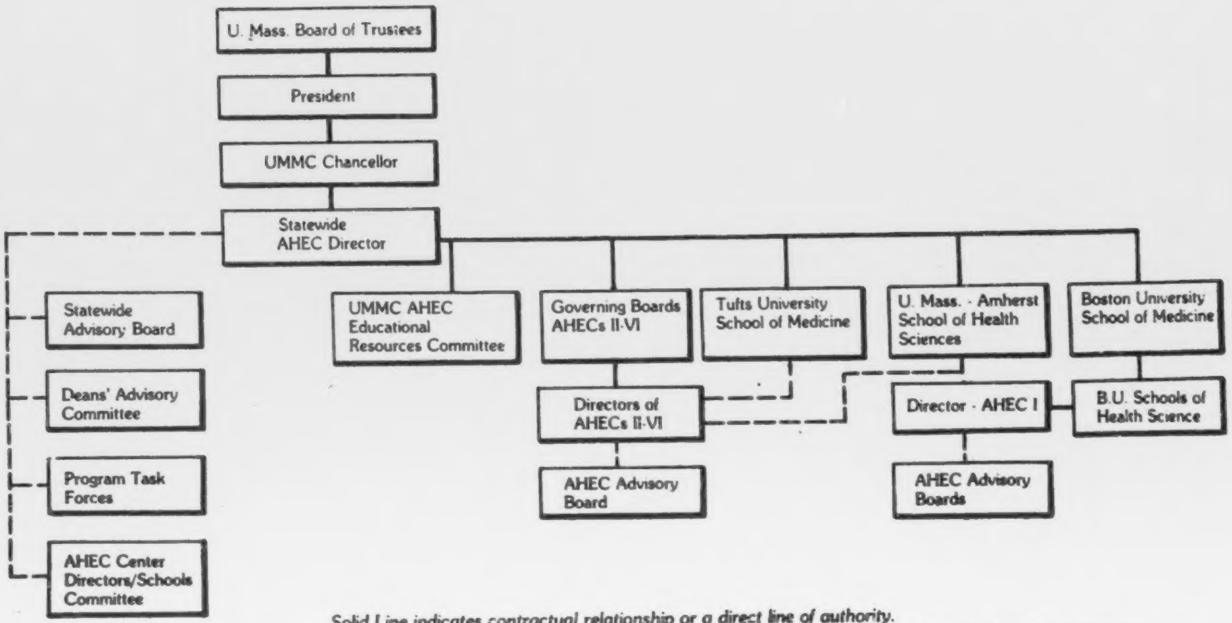
424-5256

Boston Area Health Education Center - Organizational Structure


University of Massachusetts
Medical Center
Statewide AHEC Main Contract
Boston University
School of Medicine
Dean's Office
Trustees
Boston Health and Hospitals
Commissioner's Office
Program Director
located at B.U.
Center Director
located at
Boston City Hospital
Deans'
Committee
B.U. Health Science Schools
Goldman School of Graduate Dentistry
Sargent College of Allied Health Professions
School of Medicine
School of Nursing
School of Social Work
Advisory Board

Solid Line indicates contractual relationship or a direct line of authority.
Broken Line indicates an advisory relationship or an arrangement for provision of educational resources.

Figure 2 ***Massachusetts Statewide AHEC Program - Organizational Structure***


U. Mass. Board of Trustees
President
UMMC Chancellor
Statewide AHEC Director
Statewide Advisory Board
Deans' Advisory Committee
Program Task Forces
AHEC Center Directors/Schools Committee
UMMC AHEC Educational Resources Committee
Governing Boards AHECs II-VI
Directors of AHECs II-VI
AHEC Advisory Board
Tufts University School of Medicine
U. Mass. - Amherst School of Health Sciences
Director - AHEC I
AHEC Advisory Boards
Boston University School of Medicine
B.U. Schools of Health Science

Solid Line indicates contractual relationship or a direct line of authority.
Broken Line indicates an advisory relationship or an arrangement for provision of educational resources.

association of american
medical colleges

March 30, 1984

Mr. Robert Docksai
United States Senate
Committee on Labor and Human Resources - SD-428
Washington, D.C. 20510

Dear Mr. Docksai:

I am most belatedly submitting to you the responses of Charles Terrell, AAMC witness at the March 14th Labor and Human Resources Committee hearing, to written questions from Chairman Hatch. I hope that these responses can still be included in the hearing record; if not, I would greatly appreciate your forwarding them to Chairman Hatch so that he can be aware of the AAMC's thinking on his concerns.

I thank you in advance for your help at this extremely busy juncture.

Sincerely,

David Baime

David Baime
Legislative Analyst

Enclosures

Question One:

In my personal experience as a financial aid officer at Boston University counseling students on a typical $27,000 budget for the 1984/85 school year, which projects tuition at $15,000 and living/educational costs at $11,500, an optimal combination of financial aid programs from federal, state and institutional sources follows:

$5,000	- GSL
$10,000	- Service Contingent Federal Loans
$1,000	- State grant
$11,000	- Institutional loan/scholarship

This combination of programs reflects our belief that student funding should be a shared responsibility with institutional contributions matching that from the federal loan and state grant programs.

The Boston University School of Medicine administers 30 named scholarship funds, generating an average yearly income of $3,000 each. Our emphasis, however, is in the area of student revolving loans. We administer 40 named non-federal student revolving loan funds which generated $800,000 in 1983/84, with approximately $1,245,900 in outstanding notes. We are capitalizing our major student revolving loan fund through endowments, gifts and tuition income. We will add $500,000 dollars to this fund in 1984/85 and hope to contribute $600,000 per year each year afterwards. Ours is a hard money commitment designed to remove every needy student from the need to borrow HEAL loans or their equivalents. If we are able to follow our capitalization schedule and all repayments and interest are lent again each year, after 50 years the fund will be capable of making loans totalling about $42,000,000. The loan capacity will increase about 2.5 times each 10 years. With this simple 2% in-school, and 9% post-graduate, 10 year repayment plan loan, students will repay 1/2 to 2 times the amount borrowed versus repaying 6 to 14 times the amount borrowed under HEAL.

Question Two:

While several studies, most notably that by the Graduate Medical Education National Advisory Committee (GMENAC) have predicted that, if the production of physicians continues at its current rate, a surplus of physicians will be created in the United States, the AAMC has taken no official position with respect to this issue. It is a relatively straightforward calculation to estimate the expected physician population, given the current production rates. On the other hand, what absolute numbers of physicians or what physician/population ratio warrants designation as "surplus" is not a matter of fact but of judgment related to supply/demand considerations. On this question, there is no consensus and, certainly, no national policy. The methodologies for estimating demand leave much to be desired. Many argue that the demand for health services is virtually infinite and that the apparent demand at any time is simply a function of ability to pay; demand rises in times of prosperity and falls in times of recession. Some health analysts believe that increasing the supply of physicians is an important device for creating price competition and thereby lowering health care costs. Others are convinced that a continuing high rate of production of physicians will result in reduced physician incomes, in the underutilization of valuable national talent, and in discouraging the most talented from entering the profession.

In summary, the number of physicians likely to be available at any future date is highly predictable but the significance of this number in relation to potential demand for services is difficult to interpret.

Even if a broad consensus existed that medical school enrollment should be reduced, absent a national policy, the implementation of such policy would present serious problems on a number of counts. For instance, to deny American students access to first-class medical education in the United States while students unable to meet the admissions standards of American schools could still avail themselves of opportunities for an inferior training experience in Caribbean schools would open the American educational establishment to severe criticism. To undo the very substantial size of full-time medical school faculty, expanded in response to an undeniable need two decades ago, could not be accomplished overnight; tenure contracts are tenure contracts. Last but not least, an orchestrated effort by medical schools to reduce enrollment through a carefully coordinated and national plan could easily be interpreted as a monopolistic act to "restrain trade".

Against this background the AAMC believes that the question posed embodies two separable issues: student support and the optimum number of physicians for the United States.

The fact of the matter is that student financial assistance from all sources is still inadequate. Moreover, even if the recommendations of the GMENAC report for reduction in medical school enrollments were accepted, the number of borrowers and the extent of borrowing would not be reduced significantly. Finally, it would appear to the AAMC to be highly unfair to deny educational opportunity to students seeking to become physicians on grounds of a putative future surplus of health care providers, at a time when no consensus on whether or not a real surplus is in store for the country is discernable.

Question Three:

Medical education in the United States is costly primarily because it is labor intensive. In contrast to the process in many countries, where it is almost entirely didactic, that is, provided through lectures to large groups, medical education in the United States is characteristically based on bedside teaching, tutorials, conferences and seminars. All of these areas are carried out with small groups of students and, therefore, require large faculties. Faculty in turn must be recruited in a competitive market. Faculty salaries in clinical departments must be large enough to attract physicians with alternative career opportunities in the private practice of medicine; faculty salaries for preclinical departments must meet the competition provided by industry--pharmaceutical and biotechnology companies. Thus, there is no way to acquire a high quality faculty without matching salaries established by phenomena beyond the cost control of the medical schools.

Medical students have never payed more than a small fraction of the cost of their medical education, and medical schools as a matter of policy have long resisted securing any more than a small fraction of their costs from their students. Despite the rise in costs that began in the early 1970's, most schools resisted the impulse to increase tuitions for a long time, with the major trend to do so beginning only after the disappearance of the Federal capitation support in the middle third of the decade.

The major device employed by the schools to increase their revenue streams from sources other than tuition has been through the activities of faculty members to provide health services. Organized under a variety of forms but commonly known as "faculty practice plans", many faculty members not only generate substantial fractions of their own salaries but also funds that are used to support the salaries of departmental colleagues more heavily engaged in research and teaching. The schools have also redoubled their efforts to secure endowment income, although much of this is devoted not to reducing tuition but to assisting students to meet costs through scholarship aid. Finally, rising costs have sensitized school administrations to the imperative of controlling costs and a whole variety of sensible measures to control and decrease these have been adopted, even though their aggregate impact has been relatively small.

Dr. SUNDWALL. Well, thank you very much, gentlemen. I appreciate the time and effort that goes into preparing this testimony and traveling here, and we appreciate your coming.

Senator Hatch, the chairman, has prepared questions for each of you, which I would like to submit to you and have you answer in writing, and then put in the record. I think Senator Kennedy does as well. And, as Senator Hatch has said, all other Senators who would have an interest will be able to do the same thing.

And I would like it put in the record that we understand this legislation impacts certainly on more than physician training and nurse training. There are many other health professionals that are interested in this legislation and training of their students is supported.

So, therefore, the record will stay open until March 23 for all interested organizations in putting a statement into this record.

So, if there are no objections, I would like to recess this hearing at this time.

[The hearing adjourned at 12:01 p.m.]

APPENDIX

ADDITIONAL STATEMENTS SUBMITTED FOR THE RECORD

American Academy of Family Physicians

American Association of Colleges of Pharmacy

American Association of Colleges of Podiatric Medicine

American Association of Dental Schools

American Association of Nurse Anesthetists

American Dental Association

American Hospital Association

American Physical Therapy Association

American Society for Medical Technology

American Society of Allied Health Professions (February 23, 1984)

American Society of Allied Health Professions (March 15, 1984)

American Speech-Language-Hearing Association

Association of American Medical Colleges

Association of American Veterinary Medical Colleges

Association of Schools of Public Health

Federation of Associations of Schools of the Health Professions

Howard University

Mount Sinai Medical Center

National Association of Pediatric Nurse Associates & Practitioners

Society for Research and Education in Primary Care Internal Medicine

Society of Teachers of Family Medicine

Boston University School of Medicine--Boston City Hospital

American College of Nurse-Midwives

American Nurses' Association

American Association of Colleges of Nursing

National League for Nursing

American Association of Nephrology Nurses and Technicians

Association of University Programs in Health Administration

Association of Teachers of Preventive Medicine

Association of National Health Service Corp Scholarship Recipients (ANSR)

American Academy of Pediatrics

Data on Women and Minorities in the Health Professions

Summary of Health Professions Training Assistance Act of 1984

American Psychiatric Association:
   Statement of February 29, 1984
   Statement of March 26, 1984

Blue Cross and Blue Shield Association

AV-MED Health Plan

National Association of State Mental Health Program Directors

Atlantic Emergency Medical Services Council, Inc.

Department of Health and Human Services' Responses to Questions Subsequently Submitted for the Record by Committee Members

WRITTEN STATEMENT
Of The
AMERICAN ACADEMY OF FAMILY PHYSICIANS
Submitted to The
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Re: Health Professions Reauthorization Legislation

The American Academy of Family Physicians, representing nearly 57,000 family physicians and medical students in each of the 50 states as well as the District of Columbia, Puerto Rico and the Virgin Islands, appreciates the opportunity to comment on legislation reauthorizing health professions education programs. Specifically, we would like to comment on reauthorization of Sections 780 and 786 of the Public Health Service Act which authorize funds for the support of family practice.

Section 780 provides for grants to schools of medicine to establish, maintain and/or improve academic administrative units to provide clinical instruction in family medicine. The academic administrative units must be comparable to those for other major clinical specialties with respect to status, faculty and curriculum and must control a three-year family practice residency program. The funds authorized by Section 780 have been used to enhance family practice within U.S. medical schools, with results that more students exposed to family practice while in medical school have chosen to pursue residency programs in family practice. The maintenance of this academic base for family practice within medical schools is crucial to the specialty's ability to remain viable in an environment of scarce economic resources. Since funds were appropriated for this program in 1980, 55 allopathic medical schools have received grants to support family medicine departments.

Section 786 provides grants to support residency programs in family practice, faculty development, and predoctoral training in family medicine. The funds authorized by Section 786 have been used to establish new and maintain and improve existing family medicine residency programs. The family practice residency teaches comprehensive, preventive care in an ambulatory setting -- a format critically different from traditional graduate medical education, which focuses on inpatient care. Graduates of family practice residency programs are able to treat the vast majority of the health problems of their patients, and because of the emphasis on preventive, ambulatory care, cost effectiveness is promoted. Currently 260 family medicine projects are funded by the Section 786 authority.

Fifteen years ago this country experienced a severe shortage of physicians, a problem exacerbated by both geographic and specialty maldistribution. Congress responded to the need for making medical care accessible to the general population by creating a variety of programs designed to increase the numbers of physicians, as well as to address the geographic and specialty problems. As part of this Congressional effort, funds were authorized for programs to train family physicians. While many of the programs have since been discontinued as the aggregate number of physicians has increased, targeted support toward family practice has remained a priority.

With the assistance of generous federal support, family practice in the United States has experienced tremendous growth -- from 15 approved residency programs in 1969 to 388 at the present time. As shown in Attachment A, the number of residents now in family practice residency programs is 7,409. This dramatic increase in the number of residency programs has had a significant effect in correcting the problems of specialty and geographic maldistribution.

I would like to share with you some data concerning the practice locations of family practice residency graduates, as well as data addressing the percentage of graduates who stay in the specialty of family practice. Survey data that the AAFP has collected since 1975 shows that graduates of family practice residency programs are locating their practices in rural as well as urban areas. As you will note in Attachment B, approximately 50% of these family physicians entered practice in communities with populations of 25,000 or less, and over half of these are locating in areas not within 25 miles of a large city. These figures demonstrate that increased patient access to medical care has been a direct result of the growth of family practice in this country. With respect to retention in the specialty of family practice, survey responses from 1,591 individuals who completed family practice residency training in July 1983 indicate that less than 4 percent intend to pursue other specialty or subspecialty training. We believe this data shows that a sound investment of limited federal resources is in family practice training programs.

However, the progress that has been made can only be maintained through continued federal support to family practice residencies and departments of family medicine. Federal funding is uniquely vital to the operation of family practice residency programs because the residencies are themselves unique. They do not fit the traditional graduate medical education mold and, as such, cannot live up to what one independent study from the University of Missouri at Columbia calls the "unspoken expectation...that primary care education, in common with other graduate medical education, ultimately must be supported largely from patient care income." This 1981 study documents what family medicine educators have been facing: uncontrollable factors keep costs high and patient income low. While traditional theory holds that approximately one-half of programs' costs should be recoverable through income from patient services, reality shows that to be an unrealistic expectation for family practice. A national survey in 1975-76 by the Health Planning Resource Center at the University of Wyoming showed that the average family practice residency generated only 20% of total program costs through patient revenues; a conclusion borne out again in the University of Missouri study.

Third-party reimbursement falls short as a financial foundation for family practice training because such coverage has a bias toward inpatient care. Those skills and procedures which are taught to family practice residents, and which emphasize ambulatory care and disease prevention, contribute to better health and more cost effective health care but do not generate patient revenues sufficient to underwrite graduate training in family medicine.

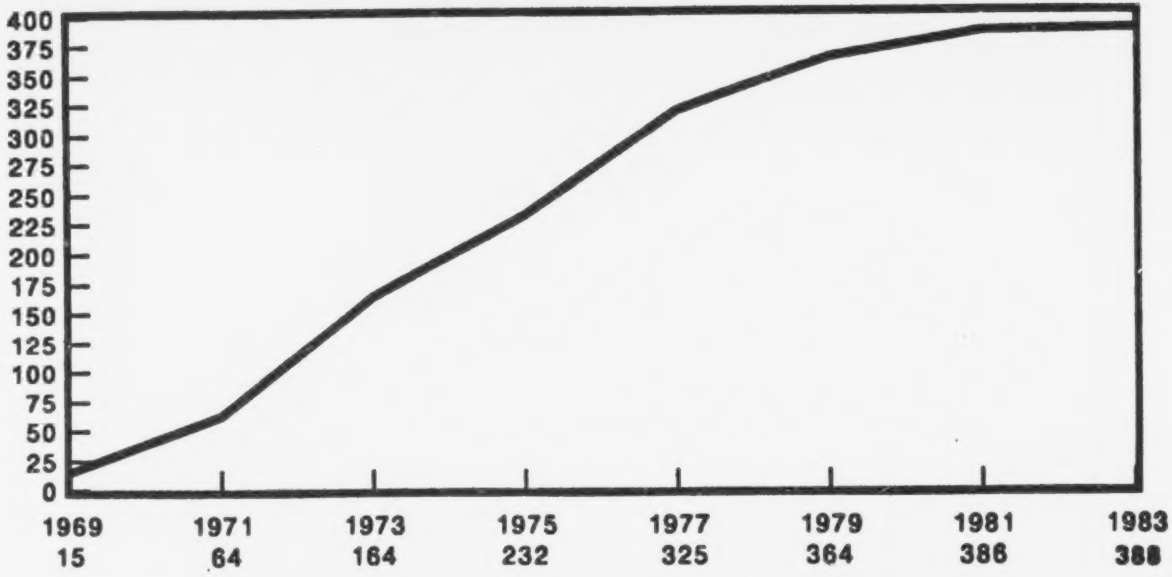
The AAFP and family medicine educators continue to seek viable alternative sources for meeting program costs; but for now, federal support is crucial. To quote the University of Missouri study: "The future of family medicine education is highly dependent upon a widespread understanding that its financing needs are different. Family medicine has been supported as a national priority with high standards for training and certification, a potential for overcoming maldistribution problems, and an emphasis upon ambulatory rather than expensive inpatient care. In a sense, these are societal as well as program goals and a continued sharing of the costs of training is essential."

The AAFP in conjunction with the American Society of Internal Medicine has been working with the Senate Finance Committee and the Health Subcommittee of the House Committee on Energy and Commerce to have language included in the reconciliation package which would require a study of ways to modify the existing physician reimbursement system under Medicare in order to eliminate inequities that exist between reimbursement levels for procedural versus cognitive services. Additionally, the House language makes particular mention of inequities in relative amounts paid to physicians by type of service, locality and specialty. The AAFP is hopeful that, should these provisions be enacted, the resulting study will provide Congress with potential legislative solutions to the current payment inequities. Such changes in the Medicare payment system will be beneficial in assisting family practice residency programs to generate a greater percentage of the necessary revenues from patient care income, although it is not known at this time if these unique residency programs can ever compete financially with inpatient-based residency programs and reach a point where targeted federal assistance is no longer necessary.

The AAFP believes that the funds expended to date have resulted in improved access to high quality comprehensive medical care. The Academy therefore requests that the committee reauthorize Section 780 at the current authorization level, and reauthorize Section 786 with a slight increase in the authorization level. The rationale for this is that while the appropriations levels for Section 780 have consistently been substantially lower than the authorizations provided, the appropriations for Section 786 have been at or near the authorization levels. We believe that this federal investment in family practice has and will continue to yield beneficial results to society.

Attachment A

ACCREDITED FAMILY PRACTICE RESIDENCIES
JULY 1983



The American Academy of Family Physicians AAFP 150-B

ATTACHMENT B

AAFP Reprint No. 155I

American Academy of Family Physicians

REPORT ON SURVEY OF 1983 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 2117. Of this number 1632 (77%) responded. Of these respondees, 1591 indicated the type of practice arrangement and 1363 specified the size of the community in which they plan to serve. A summary of the results as of July 1983 follows.

The data from 1977, 1978, and 1979 has been re-analyzed to conform with the 1980-1983 statistics. Caution must be exercised in comparing data previous to 1977 because of changes made to data analysis. However, the revised 1977-1979 data may be directly compared with the 1980-1983 data with confidence.

PRACTICE ARRANGEMENTS OF 1983 GRADUATING RESIDENTS

Type of Practice Arrangements	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	336	21.1%
Multi-Specialty Group	154	9.7%
Two-Person Family Practice Group (Partnership)	245	15.4%
Solo	254	16.0%
Practice (arrangement not specified)	43	2.7%
Military	121	7.6%
Teaching	62	3.9%
USPHS	133	8.3%
Emergency Room	97	6.1%
Hospital Staff	25	1.6%
Research	4	.3%
Administrative	1	.1%
Further Training	30	1.9%
Fellowship	30	1.9%
None of the above	56	3.5%
	1, 591	100.0%

DISTRIBUTION OF 1983 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cummulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large city	112	8.2%	8.2%
Rural area or town (less than 2500) within 25 Miles of large city	26	1.9%	10.1%
Small town (2500-25,000) not within 25 miles of large city	342	25.1%	35.2%
Small town (2500-25,000) within 25 miles of large city	191	14.0%	49.2%
Small city (25,000-100,000)	246	18.1%	67.3%
Suburb of small metropolitan area	40	2.9%	70.2%
Small metropolitan area (100,000-500,000)	122	9.0%	79.2%
Suburb of large metropolitan area	146	10.7%	89.9%
Large metropolitan area (500,000 or more)	81	5.9%	95.8%
Inner city/low income area (500,000 or more)	57	4.2%	100.0%
	1, 363	100.0%	

CE: 7/18/83

aacp
AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY
4630 Montgomery Avenue • Suite 201
Bethesda, Maryland 20814
(301) 654-9060

John F. Schlegel, Pharm.D., M.S.Ed.
Executive Director

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March 23, 1984

The Honorable Orrin G. Hatch
Chairman, Committee on Labor
and Human Resources
United States Senate
527 Hart Senate Office Building
Washington, DC 20510

Dear Senator Hatch:

The following is the statement our Association wishes to be included in the official record of the Committee's hearing on the Health Professions Training Assistance Act reauthorizing programs in Title VII of the Public Health Service Act.

Statement of the
American Association of Colleges of Pharmacy
to the
Senate Committee on Labor and Human Resources on Reauthorization of Title VII of the Public Health Service Act

The American Association of Colleges of Pharmacy, on behalf of the nation's 72 colleges of pharmacy and the 19,000 future pharmacists they are preparing to serve the public, appreciates this opportunity to contribute to the Committee's deliberations on reauthorization of essential federal programs for health professions education.

The Federation of Associations of Schools of the Health Professions has submitted a statement for the record along with a detailed legislative proposal for programs common to all health professions schools and students. Our Association was an active participant in the development of the FASHP proposal and fully endorses its recommendations. In particular, we wish to point out the ways in which the programs as described would benefit pharmacy education.

1. Student Assistance Programs

Because all pharmacy schools are concerned about their continuing ability to recruit qualified students sufficient to meet the future service needs of the public, federal student assistance programs have our highest priority. Specifically, the following programs are most important.

- New Loan In-Kind Repayment Program

  AACP supports establishment of this new program because it will address two problems simultaneously -- unacceptably high student indebtedness and the attraction of graduates to critical, but low paying, service roles.

  Although the length of training and, therefore, the cost of a pharmacy education may not be as great as that of other health professions, neither are anticipated annual salaries as high. The average pharmacy graduate can earn about $25,000 per year upon entering the profession and is not likely to earn more than $35,000 annually at the height of his or her career. These relatively modest salaries will not support excessive educational debts. The Loan In-Kind Repayment Program would provide students the chance to partially repay their educational loans with much needed public service.

  The service roles eligible for repayment include several which are critical to meeting the nation's health and wellness needs in the areas of patient information and drug therapy. Pharmacy students could choose employment in:

  - Academic Pharmacy where the loss of faculty to higher paying positions in industry is a growing concern both in terms of schools' capacity to educate future pharmacy practitioners and scientists' ability to maintain important pharmaceutical research programs.

  - Public hospitals and other institutions which require the services of clinically trained pharmacists to counsel patients and other health professionals in the appropriate use of medications as well as to provide more cost effective drug delivery systems.

  - Skilled nursing facilities where pharmacists' drug therapy monitoring can prevent unnecessary human suffering and greatly reduce drug costs, especially for the elderly.

- Health Professions Student Loan Program

  Pharmacy students are highly dependent on this program; about 20 percent of all pharmacy students required a Health Professions Student Loan this year. The continued viability of this program is essential for future students. Our schools have demonstrated how important this program is by their efforts over the last year to reduce borrower delinquency and maximize the funds available to make new loans. The FASHP legislative proposal outlines in detail measures which would greatly assist schools in the collection of HPSL funds. We strongly urge the Committee to incorporate these provisions in reauthorizing legislation.

Further, approximately a dozen pharmacy schools which entered the program since 1971 have inadequately capitalized HPSL revolving funds. New authority for appropriations for these schools is necessary.

- Exceptional Financial Need Scholarships

  This year over 200 exceptionally needy pharmacy students qualified for these first year scholarships. Only 52 students received an award because of inadequate appropriations. As recommended by FASHP, each school should be authorized to receive two EFN scholarships so that every school is able to offer a place in its class to students who otherwise would not pursue a pharmacy career.

- Disadvantaged Assistance

  AACP member institutions are committed to continuing pharmacy's progress in recruiting students from disadvantaged backgrounds to a career in pharmacy. Much progress has been made, but all schools must continue their efforts. We believe the modifications proposed by FASHP will produce even better results in the future.

2. Critical Special Projects

Pharmacy schools concur that our most pressing institutional needs are in the areas of faculty development, curriculum innovation and establishing new, nontraditional clinical training sites and modes. The FASHP proposal discusses these needs in depth. Authority for vitally important demonstration projects in each health profession will cost very little, but can have a great impact for all schools.

3. Equipment and Instrumentation for Teaching and Research

Like high education institutions in general, pharmacy schools urgently need to replace outdated and obsolete equipment used for education and research programs. Scientific equipment and instrumentation is the infrastructure of health professions educational institutions. Without it, future scientists cannot be adequately trained and current as well as future research productivity will be compromised. Lack of badly needed support at this time will result in exponentially higher costs to the system at a later time.

The American Association of Colleges of Pharmacy appreciates this opportunity to offer its views and to express support of the legislative proposal advanced by the Federation of Associations of Schools of the Health Professions.

We will be pleased to provide any further assistance or information the Committee may require.

Sincerely,

John Schlegel

John F. Schlegel, Pharm.D., M.S.Ed.
Executive Director

JFS/BAR:jmt

cc: Senate Labor and Human Resources Committee Members
Steve Grossman, Health Director and Counsel
David Sundwall, M.D., Professional Staff
Westley Clark, M.D., Minority Health Counsel

**AMERICAN ASSOCIATION OF COLLEGES
OF PODIATRIC MEDICINE**

6110 EXECUTIVE BOULEVARD, SUITE 204, ROCKVILLE, MD 20852 (301) 984-9350

Statement
of
The American Association of Colleges
of Podiatric Medicine

on

Renewal of the Health Professions Education

Assistance Act

to

Senate Committee on Labor & Human Resources

March 23, 1984

Introduction

The American Association Association of Colleges of Podiatric Medicine (AACPM) represents the six colleges which educate this nation's entire complement of Doctors of Podiatric Medicine. We are pleased to have the opportunity to submit this statement for the record regarding the renewal of the Health Professions Education Assistance Act.

The Need for Podiatric Medicine

The Doctor of Podiatric Medicine (podiatrist) is a medical care specialist who has completed a four-year professional program of basic and clinical sciences. The podiatrist is skilled in the prevention, diagnosis, and the medical and surgical treatment of injuries and diseases which affect the human lower extremity.

Podiatrists provide approximately 2/3 of all foot care services in the United States. Moreover, the profession has a special and long recognized responsibility to the aged. Statistics indicate that as many as 70% of all senior citizens experience foot problems, which often affect mobility and economic independence. Additionally, diseases with age-specific qualities, such as diabetes, vascular insufficiency and arthritis often manifest themselves in foot problems, which necessitate special care. The 1981 White House Conference on Aging recommended that "comprehensive foot care be provided for the elderly in a manner equal to care provided for other parts of the human body, to permit patients to remain ambulatory.."

In younger Americans, we note a significant increase in the need for foot health care, attributable to our society's growing commitment to fitness activities such as jogging and tennis.

The benefits of exercise in terms of reduced risk of heart attack, stroke and other diseases is well known. What is not often enunciated, however, is the obvious fact that virtually all physical exercise is impossible in the absence of good foot health. Consequently, a major factor in our national commitment to health promotion and disease prevention lies in the availability of quality foot health care.

There is genuine concern, however, that there will be inadequate numbers of podiatrists, inadequately distributed, to meet our society's burgeoning need for podiatric services. The federal government has identified some 1400 podiatric shortage areas nationwide (Federal Register, May 8, 1981).

This maldistribution is not surprising since about half of all podiatrists practice in the six states in which the colleges of podiatric medicine are located. The Department of Health & Human Services, in its 1978 Report to the President and Congress, called for a doubling of the number of practicing podiatrists by 1990, to ease these acute problems.

The federal commitment to podiatric medical education has been, and remains, vital to the success of our mission to assure the American people access to high quality foot health care. As private institutions, the six colleges of podiatric medicine lack access to the resources commonly found in large, public universities. Further, since the six colleges provide the entire national supply of Doctors of Podiatric Medicine, individual state support is minimal.

Accordingly, we call upon the Senate Labor and Human Resources Committee to endorse the reauthorization of the following health manpower programs:

Remote Site Training (Public Health Service Act §788(e))

In response to the documented shortage and maldistribution of podiatrists, Congress, in 1981, amended the Public Health Service Act (PHSA) by adding a new section 788(e). The new subsection authorized a two-pronged effort to recruit students from podiatric underserved areas and to conduct clinical training programs in similarly underserved areas. The objective of the program is to produce a significant number of podiatrists with a strong orientation to practice in areas which currently are underserved by the profession.

The Administration requested an appropriation for this effort and Congress granted a $1 million earmarking for FY 1984. The

Administration then acted quickly to implement the remote site effort, publishing program requirements in mid-January 1984 which set an application deadline of March 14, 1984.

Applications for remote site training grants will be reviewed by the National Advisory Council on Health Professions Education at its April - May, 1984 meeting, and awards will be announced July 1, 1984. The awardees will initiate their remote site efforts at the beginning of the 1984-85 academic year.

While it is expected that the remote site clinics will eventually develop a sufficient patient caseload to become self-sustaining, federal funds are necessary in the initial years to assure a strong start for this important effort. Recognizing this need, the Reagan Administration has requested a second year of funding (FY 1985) for this program in the amount of $950,000.

Title VII of the PHSA which contains the podiatric remote site training authority expires at the end of the current year. Reauthorization of this section is necessary, therefore, if this important effort is to continue. We ask that this program by authorized at a level of $5 million for FY 1985, $5.5 million for FY 1986, and $6.0 million for FY 1987.

Primary Care Residency Training/Departments of Primary Care Podiatry

In the ongoing dialogue which has led to our national consensus on the need for health promotion and disease prevention efforts, inadequate attention has been paid to the potential contribution of podiatric medicine. This is true both outside and to a great extent, inside the profession itself.

A modest federal program of stipends to support podiatric primary care residency training, and a separate program to support the establishment of departments of Primary Care Podiatry at existing and new colleges of podiatric medicine would place needed emphasis on the role of podiatric medicine in health promotion and disease prevention.

Student Assistance

Federally supported loan and scholarship programs are vitally important to students of podiatric medicine. Currently, student tuitions provide more than half of the total revenues available to our colleges. Tuition costs alone now average above $9,000 annually at our colleges, and have increased approximately 15% in each of the last five years.

Our mission to increase the representation of minorities and disadvantaged students in our colleges depends upon the availability of moderate cost student loans.

Accordingly, we endorse the reauthorization of the Health Professions Student Loan Program, and request that a level of $5 million be included for federal capital contributions as suggested by the Federation of Associations of Schools of the Health Professions. This amount could be distributed on an equitable basis to schools which have insufficient reserves.

We are well aware of the recent problems with delinquency in this program, and have been assured that the past problems have been largely corrected.

On other student assistance programs, AACPM endorses the position of the Federation of Associations of Schools of the Health Professions, (Federation) of which AACPM is an active member. We especially support the Federation's Loan-In-Kind-Repayment proposal. Federal loan forgiveness for podiatrists who practice in underserved areas would be incalculably effective in easing the maldistribution our profession faces.

The Federation also has proposed funding for renovation of teaching facilities and grants for instrumentation and equipment. Such a program would be very helpful to our colleges in their constant effort to stay abreast of technological advancements in the health sciences. We would suggest, however, that the Federation's request for a $15 million authorization for this effort in each of the next three years is clearly inadequate. A figure double that number would make only a marginal contribution to the effort to modernize our nation's medical education facilities.

AACPM also specifically endorses the Federation's position vis-a-vis the Disadvantaged Assistance and Exceptional Financial Need program. Both programs have contributed substantially to the ongoing effort of podiatric medicine to recruit and retain minority students.

Thank you for the opportunity to contribute to the Committee's deliberations on the renewal of the Health Professions Education Assistance Act. We stand ready to assist you in this important endeavor in any appropriate manner.

AMERICAN
ASSOCIATION
OF DENTAL
SCHOOLS

1625 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036

202/667-9433

March 23, 1984

The Honorable Orrin G. Hatch
Chairman, Committee on Labor &
Human Resources
United States Senate
527 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Hatch:

This statement is being submitted for the record concerning the reauthorization of health professions education programs under Title VII of the Public Health Service Act.

The American Association of Dental Schools (AADS) represents all sixty dental schools in the United States and is the only national organization concerned exclusively with the needs of dental education. We are pleased to offer the following comments on health manpower programs of vital concern to dental education.

Advanced General Dentistry/Dental General Practice Residency Program. The AADS urges that the category of eligible grant recipients be expanded to include advanced educational programs in general dentistry (AGD) while retaining the eligibility of the traditional dental general practice residency (GPR) programs. The AGD program is new; it did not exist when the manpower act was last authorized.

Both AGD and GPR programs are one year postdoctoral courses designed to provide advanced training and experience in clinical dentistry. The general practice residency program is hospital-based and structured to provide residents with experience treating medically and emotionally compromised patients, to enhance physical evaluation, emergency medicine and in-patient management skills, and to advance clinical dentistry skills. The advanced general dentistry program is a non-hospital-based advanced education experience which includes instruction and experience in all the clinical disciplines required in general practice residency programs; in addition, the new program requires training and experience in pedodontics and orthodontics, which are not required in the GPR program. The AGD program probably provides a more intensive experience in oral health care treatment of healthy ambulatory patients while the GPR residency program typically prepares dentists to treat a variety of medically compromised and handicapped patients.

The creation of the new advanced general dentistry program is a result of the demand for an additional general dentistry educational opportunity that existing residency programs could not numerically meet. The need for such advanced training in general dentistry has been echoed throughout the profession. The Special Committee on the Future of Dentistry, an extensive self-assessment effort involving practitioners, researchers, and educators, concluded that there is a significant need to broaden dentists' skills and the mix of services offered to the public. That American Dental Association committee recommended that all dental graduates be required to take a one year postdoctoral program which includes hospital experience. The committee also expressed a concern about overspecialization and recommended that increased numbers of general dentistry training places be developed in partial answer to this problem. This Association concluded in a recent study, Advanced Dental Education-Recommendations for the 80's, that there was a need to double the number of general dentistry postdoctoral positions by the mid '80's.

The Council on Dental Education (a committee within the American Dental Association which is concerned with matters related to dental education) recently published a study which demonstrates dental students' need for a transitional experience before they move into practice. Unlike medical students, dentists are exposed to all specialties in their clinical predoctoral training, however, there is an insufficient amount of time available in the four-year training program for most students to gain the experience and confidence necessary to treat a wide range of patient needs.

Dental general practice residency and advanced general dentistry programs are in critical need of additional funding; each year only half of the students who seek postdoctoral training in general dentistry are accepted into such a program. This means that only those students who graduate at the top of their class are able to be assured of placement in a residency training program. This year, over 2,000 dental seniors will seek advanced general dentistry training; however, less than 900 will actually receive this primary care experience.

Federal funding is extremely important to the initiation of the additional programs necessary to meet this major need. AADS recommends that 15 percent of what is made available to family medicine be earmarked for dental general residency and advanced general dentistry programs; we recommend a funding authorization level of $42 million for the next three years with 15 percent set aside for dental programs. We feel that $6.3 million is the minimum amount necessary to continue growth in the hospital-based GPR programs while initiating federal support for the new advanced education general dentistry programs.

A Loan In-Kind Repayment Program for Graduates of Health Professions Schools. The Association supports a Loan In-Kind Repayment (LIKR) program for graduates of health professions schools as proposed by the Federation of Associations of Schools of the Health Professions (FASHP). We believe the LIKR program would help alleviate serious health personnel shortages in teaching, research and public service areas where jobs are not being filled because they offer salaries which are insufficient to support graduates with today's heavy indebtedness.

In recent years the cost of dental education has risen dramatically and certain trends concerning career selection among graduates have begun to emerge. The average graduating debt for dental students in 1983 was $28,900, an increase of 128 percent since 1978. In 1983, three out of four graduating dental students anticipated indebtedness of at least $20,000. In its 1983 Survey of Dental Seniors, our Association reported that the percentage of seniors planning to pursue solo practice has decreased, while the proportion planning to work in partnerships or group practices has increased. The percentage of seniors planning to enter private practice as an employee continues to increase. The percentage of graduating students seeking employment in a private practice owned by another party has increased from 19 percent in 1978 to almost 35 percent of graduating students in 1983. Meanwhile; the percentage of graduating students seeking positions in teaching, research or administration has remained stable at approximately 1 percent for the last six years, and those seeking positions in government service has declined dramatically from almost 20 percent to just over 10 percent.

With these trends in mind, the Association endorses the efforts to create a federal program of loan repayment which encourages the selection of careers in teaching, research and public service, by providing forgiveness of student indebtedness. The LIKR program provides that federal direct loans and federally insured or guaranteed loans would be eligible for inclusion. The student would elect participation in LIKR just prior to entering the workforce, and the federal government would contract to pay 20 percent of the total principal per year up to an annual maximum of $20,000. The maximum federal obligation under this program would be for four years and 80 percent of the participant's loan. The participant, in turn, would be obligated to one year of service in a LIKR-eligible job for each year that the federal government repays a portion of the student's indebtedness. Each participant would be required to agree to a minimum of two years of service under the LIKR program.

The Secretary of the Department of Health and Human Services would be authorized to enter into 2-, 3-, or 4-year agreements with the participant. During the service period the participant would pay the interest on outstanding loans while the government could pay its obligation at the beginning of the borrower's service thus saving substantial amounts of money in interest charges that would otherwise have been payable on the outstanding loan balances. This efficiency is an extremely attractive feature of the LIKR program.

The Association believes that the self-limiting nature of the proposed program is particularly attractive since only specific categories of jobs can be offered to participants willing to take them. Through the rulemaking process, each locale would identify the employment catefories most needed and the professionals who would be eligible to fill those jobs. Our Association expects that academic and research positions at dental schools, staff dentists at hospitals and nursing homes, and public health dental officers would be identified as the most pressing employment needs for dentists.

The Association believes that the costs projected by FASHP related to this program are accurate, since 1983 graduating dental students had debts ranging from almost $24,000 in public institutions to almost $38,000 in private institutions. Therefore, the AADS enthusiastically supports the creation of a Loan In-Kind Repayment program and recommends an appropriation of $20 million in FY 1985, $25 million in FY 1986, and $30 million in FY 1987.

Health Professions Student Loan Program. According to 1983 data collected by the Association, over 96 percent of 1983 senior dental students borrowed from at least one loan source; almost 35 percent of these students borrowed from the Federal Health Professions Student Loan program. Given the utilization of the HPSL program by needy dental students, we believe it is essential to extend the date for liquidation of loan assets to 1992 so that student loans can continue to be made from revolving funds. The Association also supports a statutory change which would allow any "excess cash" in a particular school's fund be reprogrammed to other schools participating in the HPSL program rather than reverting to the U.S. Treasury. We support proposals made by the Administration which would allow schools to increase the penalties they could charge delinquent borrowers and recommend that schools be permitted to assess a penalty charge not to exceed 6 percent of the overdue amount for loans more than sixty days past due. We believe that this change would assist dental schools in improving further their debt collection efforts.

In addition, the Association supports the amendment of this statute so that schools would be granted access to Internal Revenue Service address list "skip-tracing". The use of IRS skip-tracing authority would assist schools in locating delinquent borrowers. Further, the Association receommends that schools be granted the authority to assign uncollectable loans to the government for collection when the schools have demonstrated good faith efforts in the pursuit of delinquent borrowers.

The HPSL program serves as an important component of funding sources for dental students as they seek their professional education. Over the past two years the program has been subjected to much adverse publicity and controversy, and both dental education institutions and student borrowers have been confused and concerned about the viability of the program. In support of the premise that those institutions and students who rely on these loans deserve a stable environment, the Association supports the following statutory changes:

1. The performance standard which measure a school's compliance with regulations should be reasonable and achievable for educational institutions.
2. A school's administration and collection practices concerning loans distributed prior to 1983 should not be reflected in the school's performance standard. However, the schools should undertake good faith efforts to collect old loans.
3. The promulgation of regulations concerning the administration of the program should be developed through the notice and comment process, and all schools should be granted a hearing on the record prior to possible suspension from active participation in the loan program.

AADS supports the proposed statutory language previously submitted to the committee, which would effect these changes. Finally, our Association endorses the concept of providing new Federal Capital Contributions to schools that have not been active participants in the program for a sufficient amount of time to establish a viable revolving fund.

Disadvantaged Assistance: Health Careers Opportunity Program. Since the inception of the disadvantaged assistance program, dentistry has demonstrated some degree of success in the recruitment and retention of qualified disadvantaged students. Despite the successes, the profession continues to underrepresent minority, women, and economically disadvantaged students. Since 1978, the percentage of minority groups represented in dental education remains at approximately 10 percent. The percentage of females in dental education has increased substantially from just over 10 percent in 1978 to over 18 percent in 1983. However, the percentage of women in the profession is still substantially less than their proportion in the general population. Finally, the Association has documented a distressing trend which indicates that since 1978 the percentage of parents of students with incomes less than $20,000 a year has decreased from over 36 percent in 1978 to less than 18 percent by 1983. The percentage of parents in the middle income level is now slowly declining, while the percentage of parents with incomes over $40,000 a year has more than doubled since 1978.

The Association remains committed to the goal that qualified disadvantaged students must have access to health professions education. The Association believes that health professions education must be available to individuals who are disadvantaged by environment, family income, education, race or ethnicity, and sex. Therefore, we support not only the continued authorization of the disadvantaged assistance program, but also the clarification of funding preferences so that health professions schools remain the primary recipient of funding for programs designed to attract, retain, and graduate disadvantaged students.

Exceptional Financial Need Scholarships. Our Association supports the continued authorization and expansion of Exceptional Financial Need (EFN) scholarships which provide access to dental education for students with "zero financial resources." The EFN program is the only Federal scholarship program for dental students and symbolizes this nation's commitment to assist talented applicants from low income families in securing an education in the health professions. AADS recommends that the exceptional financial need scholarship program be expanded to provide a minimum of 2 scholarships per year at each health professions school. During the 1983-84 academic year, 361 exceptional need scholarships averaging $15,525 were awarded to currently eligible health professions schools. Based on these amounts the Association recommends that 748 scholarships averaging approximately $15,525 be awarded to the schools of the health professions in the following manner:

Profession	Number of Schools	Number of Scholarships	$ EFN (Average)
Dentistry	60	120	$1,863,000
Medicine	127	254	3,943,350
Osteopathy	15	30	465,750
Veterinary Medicine	27	54	838,350
Optometry	16	32	496,800
Pharmacy	72	144	2,235,600
Podiatry	6	12	186,300
Public Health	23	46	714,150
Health Administration	28	56	869,400
Total	374	748	$11,612,700

Health Education Assistance Loan Program. Since the inception of the HEAL program in 1978, the Association has seen a dramatic increase in utilization of this loan program. Currently more than one senior in five borrows from HEAL, whereas funds for this program were not distributed before September 1978. Because dental students appear willing to borrow under the HEAL program at the current interest rate which approximates commercial rates, the Association supports extension of the program's authority and modest increases in the program's authorization levels, as follows:

Fiscal Year 1985	$275 Million
Fiscal Year 1986	$290 Million
Fiscal Year 1987	$305 Million

Matching Grants for Renovation of Teaching Facilities and Grants for Instrumentation and Equipment. For a period of approximately ten years the Federal government contributed more than $1 billion to health professions schools across the country for construction and equipment of teaching and research facilities. Since 1975, the financial support of health professions educational institutions for either new construction, renovation, or the replacement of equipment has been drastically reduced. When this trend became evident, the Association polled the nation's dental schools to try to estimate the impact of the loss of federal funds on the quality of our educational institutions. In 1978 the Association surveyed the nation's dental schools with the following results. The schools estimated that within five years they would need approximately $32 million for the replacement of fixed equipment. The schools projected their need at approximately $87 million over a five year period for the alteration, renovation, and modernization of facilities. As the Association attempts to balance the import of these staggering estimates against the continued need for federal fiscal responsibility and decreased expenditures, the Association supports fully the concept that Congress implement a grant program in the amount of $15 million for fiscal years 1985, 1986, and 1987. The Association believes that this level of funding is a minimal commitment to meet the important goal of sustaining quality institutions for education and research among the health professions.

Special Project Authority. The Association believes that health professions education institutions must prepare for the demographic, disease pattern, and technological changes which have transformed and will continue to transform the need for health care professionals in the future. The faculty in dental educational institutions will need to acquire particular skills in teaching and technology management which they currently do not possess. The dental curricula will need modification in order to prepare graduates to manage appropriately and efficiently the dental care needs of an aging population. Finally, dental education institutions must prepare students to accept and function within nontraditional clinical care sites in order to meet evolving demands for dental care among diverse populations. With these considerations in mind, the Association recommends continued special project authority. The Association supports the proposal that special project funds be made available to each of the authorized health professions and that competition for the funds be conducted within individual health professions. The Association supports the proposal that each profession can best determine priority areas that require special project support and how special project funds can best be utilized. The Association believes that the award of special project funds should be granted through a peer review system, with final recommendations made by the National Advisory Council on Health Professions Education.

The Association supports the proposal that special project grants awarded through the national advisory council be available for demonstration and for implementation of particular projects designed as a priority within each competing health profession. The special project authorization should amount to $10 million, $1 million for each health profession school within the authority, for demonstration/dissemination, and an additional $10 million should be available on an annual basis for implementation of high priority projects.

We appreciate the opportunity to offer these comments and would be pleased to respond to questions or comments about the concerns of dental education in the reauthorization of the health professions training assistance act.

Sincerely,

Owen R. Terry
Interim Executive Director

ORT/jf

RECEIVED APR 10 1984

AANA

March 27, 1984

The Honorable Orrin G. Hatch
United States Senate
Washington, D. C. 20510

Dear Senator Hatch:

Enclosed is a copy of testimony submitted for the American Association of Nurse Anesthetists relative to the extension of the Nurse Training Act. We are requesting a reauthorization of Section 831 of the Act and the addition of language to authorize funding to improve existing training programs specifically through advanced training support for faculty in existing programs. This latter proposal is recommended in the National Academy of Sciences' recent report on nurse training needs.

We respectfully request your support for our proposed authorization extension and the additional language. Specific language is included in Exhibit III attached to the testimony.

If you have any questions, please feel free to Richard Verville, our Washington Counsel, at 659-2900.

Sincerely,

Patrick Downey

Patrick Downey
President

Enclosure

erican Association of Nurse Anesthetists 216 Higgins Road, Park Ridge, Illinois 60068 (312) 692-7050

AANA

TESTIMONY OF
THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

March 21, 1984

AANA

SUMMARY OF TESTIMONY

The American Association of Nurse Anesthetists requests the following authorization levels for fiscal years 1985, 1986, and 1987 in this testimony: FY '85 - $1.2 million; FY '86 - $2.2 million; and FY '87 - $3.0 million. It also requests an amendment to section 831 to allow for a program to provide grants to public or private non-profit institutions to cover the cost of projects to improve and upgrade existing programs for the training of registered nurses to be nurse anesthetists which are accredited by an entity or entities designated by the Secretary of Education, including grants which provide financial assistance and support to nurse anesthetist faculty for the purpose of providing them with advanced education.

The Association feels that the quality of CRNA service coupled with its cost effectiveness, the demonstrated shortage of CRNAs, and the future increased demand for surgical services amply justifies the need for the continuance of this vital program. In addition, the trend towards degree awarding frameworks requires the preparation of more degreed CRNA faculty, which leads to the AANA's request for a modest new authority within section 831.

INTRODUCTION

This testimony is provided on behalf of the American Association of Nurse Anesthetists (AANA), a professional organization of some 22,000 Certified Registered Nurse Anesthetists (CRNA) who provide over 50% of the anesthetics in this country.

PURPOSE

The purposes of this testimony are: (1) to demonstrate the continued need for authorization of the nurse anesthetist traineeship program found in Section 831 of the Public Health Service Act; and (2) to recommend the establishment of a new authority therein.

DESCRIPTION OF CRNAs

Certified Registered Nurse Anesthetists are licensed professional nurses who have qualified themselves through academic and clinical achievements. In order to be a CRNA, one must:

1. Graduate from an approved program of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools or its predecessor;

2. Successfully pass the Certification Examination which confers eligibility for certification by the Council on Certification of Nurse Anesthetists or its predecessor; and

3. Be recertified every two years by the Council on Recertification of nurse anesthetists.

Exhibit 1 includes the general requirements required for graduation from an accredited nurse anesthesia educational program.

Nurses have been administering anesthesia in the United States for close to a century. The specialty of nurse anesthesia emerged prior to World War I and nurse anesthetists have functioned with distinction in both civilian and military settings. The practice of CRNAs is legally sanctioned in all states and other legal jurisdictions of the United States. They function as employees of hospitals, employees of physicians, as members of the federal services, or as independent contractors with patients and/or hospitals.

CRNAs are recognized in a variety of federal programs, such as: (1) the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS); (2) the Federal Employee Health Benefits Program (FEHBP); (3) the Medicare Conditions of Participation; (4) Joint Commission on the Accreditation of Hospitals (JCAH) standards; and (5) the Medicaid program. In fact, eight states permit direct reimbursement of CRNAs under Medicaid. In addition, twenty-four Blue Cross/Blue Shield plans, representing over thirty percent of all such plans, directly reimburse CRNAs. Of private insurance plans surveyed by AANA, fifty-seven percent indicate that they can provide direct reimbursement to CRNAs for anesthesia services.

JUSTIFICATION FOR CONTINUED SUPPORT

The need for continued support for nurse anesthesia education can be justified for a variety of reasons. These follow.

DEMAND

COST EFFECTIVENESS/QUALITY

Nurse anesthesia affords the means to moderate the escalation of costs associated with the provision of anesthesia services. Today, the median income of anesthesiologists, the medical specialist in this field, is reported to be $150,000 whereas the gross mean income of CRNAs in 1982 is reported as $36,748. SEE Note 1.

Research studies have demonstrated that there is no significant difference in the outcomes of care for anesthetics administered by CRNAs and anesthesiologists. SEE Note 2.

FEDERAL STUDIES

The demand for nurse anesthesia services has been demonstrated in a variety of studies. According to a 1976 study, the projected need for CRNAs ranged between 22,267 and 25,530 as of 1980. Currently there are 18,955 active-practicing CRNAs, and this produces a shortfall of from 3,312 to 6,575 compared to what was needed in 1980. SEE Note 3.

The latest study was the Institute of Medicine - National Academy of Science report entitled "Nursing and Nursing Education" which recommended: "The federal government should expand its support of fellowships, loans, and programs at the graduate level to assist in increasing the rate of growth in the number of nurses with master's and doctoral degrees in nursing and relevant disciplines. More such nurses are needed to fill positions in administration and management of clinical services and of health care institutions, in academic nursing (teaching, research, and practice), and in clinical specialty practice." Nurse anesthetists were one of the groups specifically addressed in this report.

THE AGING POPULATION

The increasing age of the American public will also contribute to an increased demand for anesthesia providers in the coming years. The Census Bureau projects that elderly Americans will double in number between the years 1980 and 2020, and that by the year 2030 one in every five people will be at least 65 years old. The life expectancy for those people born in 1982 is 74.5 years on the average, according to the National Center for Health Statistics. This type of information would point to an increased need for CRNAs in the future as well, since, as the average life expectancy continues to grow and the percentage of elderly in our population continues to rise, the demand for more complicated surgery will also increase.

COST OF NURSE ANESTHESIA EDUCATION

The cost of nurse anesthesia education is escalating because of a variety of reasons which include the inability of hospitals to fiscally support this educational endeavor to the extent it has in the past, the movement of these educational programs into academic settings at the graduate level, and the length of these programs ranging in most instances from 24-30 calendar months. This increasing cost of nurse anesthesia education has been a principal reason for the decrease in nurse anesthesia educational programs over the past decade by one-third, i.e. from 213 to 137. Prior to the mid-seventies, students often received stipends and tuition assistance from hospitals within which these programs exist but with the increasing cost contraints placed on hospitals, this support has all but dried up.

LACK OF OTHER AVAILABLE FINANCING SOURCES

The nature of the education does not lend itself to part-time study and part-time work because the classroom and clinical commitment is approximately sixty-four hours per week. It is essential to complete this curriculum since the certification in this specialty has become essentially required for entry into practice.

In addition, many of the other funded programs under the Nurse Training Act are limited in regard to applicants' eligibility, and nurse anesthesia students and/or their educational programs do not fit into many of the stated criteria. In part, funds from these programs are already committed as well, and therefore it is unlikely that student nurse anesthetists will receive significant funding from existing Nurse Training Act programs at this time.

BUDGET REQUEST

SECTION 831(a)

The AANA is requesting continuation of the Nurse Anesthetist Traineeship program and an increase in dollars appropriated and authorized for it. The fiscal year 1984 authorization for this program was $800,000, while $400,000 was appropriated to it. We are requesting that this program be expanded as follows:

Fiscal Year	# Students Assisted	Requested Funding
1985	200	$1.0 million
1986	350	$1.7 million
1987	500	$2.5 million

The monies requested are based on an assumption of providing $5,000 per traineeship.

The current nurse anesthetist traineeship program criteria follow. In order for the program to be eligible to receive grant monies for its students, it must have an eligible applicant currently enrolled, that is, a student with a baccalaureate degree. Eligible applicants must have a baccalaureate degree because of the upcoming change in the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools Standards which would require a baccalaureate degree, coupled with the trend towards the baccalaureate and masters education previously discussed.

The Division will then distribute the appropriated funds to the programs on a per eligible applicant basis, and the program will retain the ability to distribute the funds to its students who have completed at least twelve months of nurse anesthesia education as the program sees fit.

SECTION 831(b)

The AANA is requesting an amendment to Section 831 which would provide authority for funding faculty development grants for nurse anesthesia educational programs. Funding requests for this expansion of the Nurse Anesthetist Traineeship Program would result in grants to educational programs which would be used for financial assistance to undertake education towards masters and doctoral levels for CRNAs actively engaged in nurse anesthesia education. The justification for this request is based on the crucial need for academically credentialed faculty appropriate to the level of the program conducted both within the academic and clinical settings caused by the rapid movement of nurse anesthesia education into graduate programs within colleges and universities. By 1987, all accredited nurse anesthesia educational programs will be post-baccalaureate in nature.

The funding requested is based on the assumptions that masters level grants would amount to approximately $7,000 per year for two years, while doctoral grants would amount to $9,000 per year for three years. The funding based on the number of grants requested for faculty development is as follows:

Fiscal Year	# Students Assisted		Funding Requested
1985	Masters	20	$230,000
	Doctoral	10	
1986	Masters	40	$460,000
	Doctoral	20	
1987	Masters	40	$550,000
	Doctoral	30	

While the amounts of money requested may be modest for accomplishing the purpose cited, individual CRNAs have made graduate education a matter of priority and others would if their individual responsibilities would only permit. Thus it is our belief that this small number of grants would permit some outstanding CRNAs to pursue such education who could not otherwise afford graduate education. Suggested language for amending Section 831 is found in Exhibit 3.

SUMMARY

In summary, the AANA is requesting reauthorization and expansion of the nurse anesthetist traineeship program for fiscal years 1985, 1986, and 1987 to include funding for selected traineeships for nurses seeking to become nurse anesthetists and for selected CRNAs pursuing graduate study at the masters and doctoral level. The total funding requested for this program is as follows:

Fiscal Year 85 - $1.2 million.
Fiscal Year 86 - $2.2 million.
Fiscal Year 87 - $3.0 million.

CONCLUSION

We thank the Committee for its time, for its attention, and its thoughtful consideration of our request. We are hopeful that Congress will include authorization for the nurse anesthetist traineeship program to meet the need for CRNAs which will, in all likelihood, intensify in years to come. We believe that the quality of CRNA service coupled with our cost effectiveness, the demonstrated shortage of CRNAs, and the future increased demand for surgical services amply justifies the need for the continuance of this vital program. In addition, the trend towards degree awarding frameworks requires the preparation of more degreed CRNA faculty, which leads to the AANA's request for a modest new authority within section 831. We look forward to working with the Committee on this issue, and gladly offer any assistance to it as needed. Thank you.

NOTES TO TESTIMONY ON

REAUTHORIZATION OF THE NURSE ANESTHETIST TRAINEESHIP PROGRAM

Note 1: Cost-Effectiveness of CRNAs

The large differential in income between nurse anesthetists and anesthesiologists, particularly in light of the research findings demonstrating comparable outcomes of care demonstrates the cost-effectiveness of CRNAs. The latest available figures pertaining to the earnings of anesthesiologists were reported in USA Today, November 22, 1983, in which a survey conducted by the Roth Young Personnel Service was utilized. This survey indicated that anesthesiologists were the fastest growing and hghest paid medical specialist in the United States, having a median annual income of $150,200. The range of income reported was from $77,500 to $250,000. In the most recent survey conducted in the fall of 1983, previously cited in this testimony, gross mean earnings reported by CRNAs for 1982 were $36,748.

From this data, it is evident that anesthesiologist earnings are approximately four times that of nurse anesthetists and few, if any of the arguments medicine has traditionally used to justify the great spread between their earnings and those of nurses, between anesthesiologists and nurse anesthetists, can be justified. An article which has looked at these arugments and failed to find justification for them is from the September, 1982 Harper's Magazine by David Osborne, entitled "Rich Doctors, Poor Nurses", a copy of which is attached. SEE EXHIBIT 2

Note 2: Quality of Anesthesia Care and Research Documentation

Bechtoldt, A., et al, "Committee on Anesthesia Study, Anesthesia Related Deaths, 1969-1976", North Carolina Medical Journal, 42:4 (April, 1981.)

Hirsch, R.A., et al, HEALTH CARE DELIVERY IN ANESTHESIA, (Chapter 15: Forrest, W. "Outcome--The Effect of the Provider" and Chapter 16: Gilbert, J. "Outcome--Experience and Training of the Anesthetist") Philadelphia: George F. Stickley Co., 1980.

Note 3: Documentation of Demand for CRNA Services May Be Found in the Following:

Department of Health, Education and Welfare, "Supply, Need and Distribution of Anesthesiologists and Nurse Anesthetists in the U.S., 1972 and 1980", Reference No. HRA 77-31, 1976.

Institute of Medicine--National Academy of Science Study, "Nursing and Nursing Education": Reported 1983.

Exhibit I

Council on Accreditation of Nurse Anesthesia Educational Programs/Schools

Standards and Guidelines for the Accreditation of Nurse Anesthesia Educational Programs/Schools

1980

B. General Requirements:

1. The length of the program shall be a minimum of 24 months.

2. The minimum number of anesthetics administered by each student shall be 450 for a minimum of 800 hours of actual anesthesia time.

3. Minimum requirement for didactic instruction is 425 contact hours. (50 minutes = one class hour.)

4. Time activity design shall include a master class schedule reflecting the sequence of subjects, and the distribution of both class hours and clinical practice hours per specified period of the program. (A sample master class schedule is enclosed in the Appendices.)

C. Minimum Competencies Required of New Graduates of Nurse Anesthesia Educational Programs/Schools:

Competence is defined to include knowledge, judgment, skills and attitudes appropriate to the accomplishment of anesthesia care goals while affording patient safety in the performance of the function.

1. Perform a preanesthetic interview and physical assessment.

2. Evaluate patient history, physical and appropriate lab and x-ray data.

3. Develop an appropriate anesthesia care plan consistent with the overall medical and nursing regimen.

4. Perform general anesthesia for all ages and all categories of patients utilizing a broad variety of techniques and agents. (Experience in anesthesia for open heart cases is encouraged where experience is available.)

5. Manage regional anesthesia cases. (Experience in the actual administration of regional anesthesia is strongly encouraged.)

6. Use and interpret a broad variety of monitoring modalities including electronic monitors--EKG, Arterial Pressures, CVP, etc.

7. Manage fluid therapy within medical plan of care.

8. Recognize and take appropriate actions with reference to complications occurring during anesthetic management, referring to a physician those beyond the nurse anesthetist's ability to manage consistent with practice standards, policies and that degree of delegation accepted from the physician.

9. Utilize mechanical ventilators effectively.

10. Position or supervise positioning of patients to assure optimal physiologic function and patient safety.

11. Function as a team leader/member in cardiopulmonary resuscitation.

12. Interpret and take appropriate actions with reference to screening pulmonary function and blood/gas determinations.

13. Serve as a resource person for respiratory care of patients.

14. Utilize appropriate principles of basic and behavioral sciences in protecting patients from iatrogenic complications.

15. Applies crisis theory in the care of patients/families and in facilitating the function of the health care team.

16. Teach patients and health related personnel in area of expertise.

17. Recognizes personal and professional strengths and limitations and takes appropriate actions consistent with valid self-awareness.

18. Knows and functions within appropriate legal requirements as a licensed professional, accepting responsibility and accountability for own practice.

D. Academic Requirements:

1. The number of contact class hours in each division shall meet or exceed the following:

a. Professional Aspects of Nurse Anesthesia: 45 hours

(1) Department management and organization.

(2) Ethics.

(3) History of anesthesia.

(4) Legal aspects of anesthesia. (Six hours)

(5) Professional Adjustments. (To include local, state, national organizational structure and current issues.)

(6) Psychology.

b. Anatomy, physiology and pathophysiology in relation to anesthesia: 135 hours

(1) Cell physiology.

(2) Nervous system.

(3) Respiratory system.

(4) Circulatory system.

(5) Endocrine system.

(6) Excretory system.

c. Chemistry and physics in relation to anesthesia: 60 hours

d. Pharmacology in relation to anesthesia: 75 hours

e. Principles of Anesthesia Practice: Basic and Advanced. 75 hours

f. Journal Club, Seminars, Morbidity and Mortality Conferences and/or other Clinical Correlative Conferences: 35 hours

NOTE: Programs/Schools should strive to exceed the 35 required hours for conferences.

2. Objectives written in behavioral terms and course outlines

and reading lists shall be available for all subjects and shall be provided to students, faculty and consultants and/or other appropriate personnel.

3. Organization of curriculum and manner of implementation, while the prerogative of the faculty, must demonstrate a sequential arrangement consistent with providing an adequate theoretical base for practice in correlation with the clinical practicum and reflect the program philosophy.

E. Practicum Requirements:

The clinical teacher or supervisor is the professional person responsible for clinical instruction and the evaluation of performance concerning levels of knowledge, understanding, interpretation, application of principles, as well as the demonstration of skills.

1. An anesthesiologist or C.R.N.A. shall be immediately available in all anesthetizing areas at all times for consultation and/or assistance.

2. The ratio of students to clinical instructors shall not exceed 2:1 and shall be directly related to:

a. The student's period of enrollment in the program and his/her readiness to assume responsibility.

b. The physical status of the patient.

c. The complexity of the anesthetic and/or surgical procedure.

d. The ability of the instructor.

3. Basic Principles of Anesthesia Practice should include a broad-fields orientation to the practicum to include:

a. Preanesthesia evaluation of the patient.

(1) Interview techniques.

(2) Evaluation of the patient's chart.

(3) Physical assessment of the patient.

b. Charting.

c. Monitoring of vital signs.

(1) Elementary (palpitory, auscultatory and visual).

(2) Electronic.

d. Intravenous techniques.

e. Familiarization with basic anesthesia equipment.

f. Overview of anesthetic agents and accessory drugs.

g. Philosophy and ethics of anesthesia.

4. Student anesthesia management of the patient shall include:

a. Preoperative evaluation of patient to include interview, assessment and review of appropriate patient records (history/physical, laboratory and x-ray reports, etc.)

b. Development of a written anesthetic care plan to include selection of agents and techniques.

c. Administration of the anesthetic.

d. Decision making during the anesthesia management.

e. Immediate postanesthesia care.

f. Postanesthesia follow-up, including visits.

g. Implementation and maintenance of an accurate, complete anesthesia record.

5. Programs must demonstrate the availability of a broad variety and balance of clinical experience for student learning. This shall include experience in anesthesia for intrathoracic, intracranial, and pediatric (under two years of age) cases. The following types of clinical experience, by numbers, are required for each student:

a. Agents:

(1) Nitrous oxide	150 cases
(2) Intravenous barbiturates	100 cases
(3) Muscle relaxants	100 cases
(Depolarizing; non-depolarizing; including adequate recovery and/or reversal)	
(4) Intravenous narcotics, neuroleptic drugs or tranquilizers	50 cases
(5) Inhalation agents other than nitrous oxide	50 cases
(Effort should be expended to provide variety in complying with this requirement)	

b. Methods of anesthesia:

(1) Inhalation	300 cases
(a) Endotracheal (actual intubation)	125 cases
(b) Mask cases	25 cases
(2) Intravenous (actual venipuncture)	100 cases

(3) Regional (management of)	15 cases
(4) Mechanical ventilation	15 cases
c. Special cases:	
(1) Emergency surgery	25 cases
(2) Geriatrics (60 years or older)	25 cases
(3) Pediatrics (12 years or younger):	
(a) Two to 12 years	10 cases
(b) Under two years	2 cases minimum; 5 cases preferred
d. Surgical anatomical categories:	
(1) Head:	
(a) Intracranial	2 cases minimum; 5 cases preferred
(b) Extracranial	10 cases
(c) Intrapharyngeal	15 cases
(2) Neck	5 cases
(3) Intrathoracic	5 cases
(4) Extrathoracic	10 cases
(5) Abdominal:	
(a) Upper	20 cases
(b) Lower	20 cases
(6) Extremities	25 cases
(7) Obstetrics (Caesarean section or Vaginal delivery)	15 cases
e. Position categories:	
(1) Procedures in the prone position	5 cases
(2) Procedures in the lithotomy position	25 cases
(3) Procedures in the lateral position	5 cases
(4) Experience with patients in sitting position encouraged.	

f. All experiences shall incorporate patient safety aspects in the learning situation to include:

(1) Correct positioning.

(2) Safety regulations as relates to electrical, explosive, thermal or other iatrogenic hazards.

(3) Testing and first echelon preventive maintenance of equipment to be used.

(4) Infection control measures as relates to patients, personnel and equipment.

g. CPR Competency: All students shall complete the Basic Life Support Course offered by the American Heart Association (or local Affiliate) or its equivalent.

h. Encouraged experiences:

(1) Anesthetic management of:

(a) Arteriogram.

(b) Pneumoencephalogram.

(c) Cardiac catheterization.

(d) Electroshock therapy.

(e) CAT Scan.

(2) Respiratory therapy (minimum of two weeks recommended).

(3) Inhalation induction.

(4) Arterial puncture (actually performed).

(5) Arterial monitoring.

(6) Central Venous Pressure (actually performed).

(7) Swan Ganz Monitoring.

(8) Open heart surgery.

i. Actual administration of Regional Anesthesia is strongly encouraged. (Statement by the Council on Nurse Anesthesia Practice on the Administration of Regional Anesthesia by Nurse Anesthetists included in the Appendices.)

6. Affiliations.

Affiliations can be a source of added richness in both depth and breadth of a program.

a. An affiliation is necessary if there is an insufficient quantity or quality of required experience to meet student needs.

b. An affiliation should be considered if there is borderline quantity or quality of required experiences to meet student needs.

c. When an affiliation is established, there shall be a written agreement between the parent and affiliate facility, outlining the expectations and responsibilities of each.

d. Terminal behavioral objectives and guidelines shall be formulated for the affiliated experience.

e. The program director, or his designee, shall periodically visit and review all affiliations to assure that program policies are being carried out and that the objectives of the affiliation are being achieved. In most instances such reviews shall be on a monthly or quarterly basis, but under no circumstances shall they be less than twice a year.

f. The quality of clinical instruction at an affiliated facility shall be comparable to that in the parent facility.

7. Anesthesia Call Experience.

a. Each student shall have anesthesia call experience, or its equivalent, as a part of the clinical practicum.

b. To assure patient safety, and student learning, the length of the call period shall not exceed 16 hours with the following day uncommitted except for scheduled classes, Monday through Friday. The number of hours of weekend call should be in relation to a realistic amount of house anesthesia time. Students shall not be assigned to practicum following call.

c. Students may acquire their anesthesia call experience while being assigned scheduled shifts (for example, 3 pm to 11 pm or 11 pm to 7 am).

d. Behavioral objectives and guidelines shall be available for anesthesia call experiences, whether scheduled as call or on a scheduled shift.

F. Teaching/Learning Methods.

A variety of teaching methods shall be used to facilitate effective learning. These may include:

1. Discussion.
2. Demonstration.
3. Lecture.
4. Laboratory.
5. Programmed instruction.
6. Audiovisual.
7. Field trips.

8. Case Study.

9. Journal club.

10. Structured self-directed learning is encouraged. This is not to exceed 15% of the required academic curriculum reflected in this standard.

11. Other.

G. Student Evaluation.

Evaluation is an on-going process by which levels of performance and progress are determined. It is used to guide behavioral changes in the process of the student becoming a safe, competent, professional nurse anesthetist.

1. The evaluation program shall include:

   a. Testing.

      (1) Oral.

      (2) Written.

   b. Individual documented student-instructor conferences that:

      (1) Reflect student strengths and weaknesses, basis for each, and plans for continued growth.

      (2) Include student assessment of his own progress and level of performance.

      (3) Are held at regularly scheduled intervals and as necessary. Formal, written evaluation delineating student's strengths and weaknesses shall be conducted every three months. A student having academic or clinical problems should be counseled/evaluated at least every month with appropriate documentation.

   c. Clinical evaluation is an essential part of determining the quality of practice.

      (1) Informal daily review of student's written anesthetic care plan preoperatively with discussion pertaining to change/additions/deletions as required.

      (2) Informal postanesthesia review of student management of case.

      (3) Informal daily review of all student experiences.

      (4) Record anecdotal and/or critical incident notations to document formal evaluations.

2. The clinical evaluation tool used to more formally evaluate student clinical experiences should address specific categories of functions as relates to the educational objectives, i.e., it should be structured in behavioral terms. Specific categories should address, but are not limited to the broad categorizations as follows:

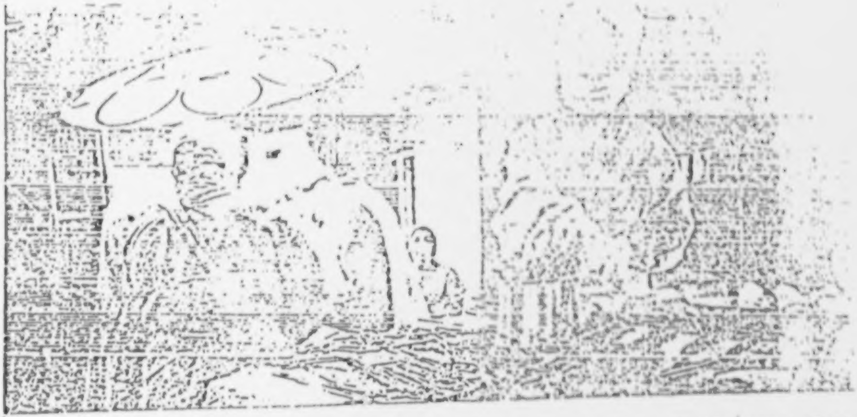
8. Case Study.

9. Journal club.

10. Structured self-directed learning is encouraged. This is not to exceed 15% of the required academic curriculum reflected in this standard.

11. Other.

Exhibit II



RICH DOCTORS, POOR NURS

Testing our notions about a fair day's pay.

by David Osbo

EQUALITY of material reward is not our nation's strong suit. To pick a nice, clean statistic, the top 10 percent of all American workers take home some twenty times what their counterparts on the bottom rung earn. West Germany, Japan, and Sweden sport ratios closer to ten to one.

Until recently, many defenders of the American Way tended to be vaguely embarrassed by such comparisons. But in the current ideological climate, American inequality tends to be quite readily and bluntly justified as the product of a free economy, unencumbered by social-democratic meddling. Do executives at large corporations average over $500,000 a year while the average American worker falls short of $15,000? Well (our president might reassure us), that is simply the market working its magic—allocating scarce resources, rewarding merit, providing incentives for the players in our economic game to develop skills, assume responsibility, take risks, or endure unpleasant travail.

The economic justification for our material inequality is not just an appealing theory: it purports to reflect how things actually work. Does it? Certainly a good deal of casual evidence suggests that it does not. American executive salaries, for example, have kept on rising in recent years even as the economic performance of American firms has deteriorated. "Any similarity between rewards received and performances demonstrated often seems almost coincidental," concluded a recent *Fortune* magazine survey of 140 companies.

But top corporate executives are a tiny minority, a relatively small number of well-born, well-positioned, or even unscrupulous individuals. To better test the connection between individual prosperity and productivity, we might look at our third largest industry, accounting for a tenth of our GNP: the health-care business.

Average earnings in health care are similar to those in other ind tries, but, as health economist V tor Fuchs puts it, "the coeffic of variation, which measures relative variance or inequality earnings, is higher for health for any other industry." In words: doctors make lots of mo ey, while nurses make little. the question is, does this vast d parity between doctors' and nurs earnings reflect the free market work, rewarding risk, skill, and fort, or is it the result of less eas justifiable causes?

As of 1980, there were a proximately 450,000 ph sicians active in the Und States, as compared about 1.2 million registered nur (RNs), 400,000 licensed pract nurses (LPNs), and almost a milli nurses' aides, orderlies, and as tants. To get these terms strai the aides and orderlies do the menial work, while LPNs genera also do physical labor.

David Osborne, a writer living in Connecticut, is married to a doctor.

changing sheets and helping patients out of bed. The RNs are in charge, with responsibility for executing doctors' orders, giving medications, and keeping track of patients' conditions. LPNs normally have only a year of training, while RNs average three years (many have bachelor's and master's degrees). The word "nurse" in the industry is used almost synonymously with RN—a custom I will follow.

According to the American Nurses Association, registered nurses earned an average of $19,381 per annum in January 1982. The figures varied from $27,865 for administrators down to $12,872 for RNs in physicians' offices (an interesting comment on doctor-nurse relationships). The most typical RNs—staff nurses in hospitals—averaged $18,331.

According to *Medical Economics*, a trade publication that publishes annual surveys of doctors' earnings, the median net income for a private, office-based physician in 1980 was $83,700. The one in eleven doctors who worked full time on the staff of a hospital made less—$61,590 in 1980—but he or she also garnered more benefits, such as retirement plans, malpractice insurance, and sometimes free offices in which to see private patients. Since physicians' earnings have recently been rising by about $5,000 a year, the office-based median is undoubtedly over $90,000 by now, and even that may be low. *Medical Economics*'s figures are provided by physicians themselves, who are considered notorious underreporters by the IRS.

Comparing doctors' and nurses' incomes is tricky, however. It is often said, on the basis of figures like those just cited, that doctors earn more than five times as much as nurses. But to generate a fair comparison one must make quite a few adjustments, all allowing room for bias. First, we are comparing an average for nurses with a median for physicians, the median being the point at which 50 percent make more and 50 percent less. According to *Medical Economics*, averages tend to run 20 percent higher than medians when it comes to physicians—placing the current average at around $110,000—because a minority of superrich doctors (heart surgeons and the like) skew the figures upward. The median may be more representative, as *Medical Economics* argues. Still, over a third of all office-based physicians made over $100,000 even in 1980, and by 1982 the typical doctor could expect many good years at well over the magic hundred grand. Splitting the difference, let us take $100,000 as a fair average for office-based physicians in 1982.

Doctors, however, work longer hours than nurses. *Medical Economics* says the median is sixty-one hours, a figure that could well be inflated, since part-time physicians are probably less likely to return the survey form than those with full practices (and other sources give lower figures). Full-time RNs work an average of forty-one hours a week, according to the Bureau of Labor Statistics. But in the nurses' case the figure should probably be adjusted upward, since many nurses routinely put in unpaid overtime to complete their paperwork and make sure the next shift has adequate information on its patients.

Again using strictly seat-of-the-pants methodology, let us say doctors work sixty hours a week and nurses forty-five. So, for a fair comparison of earnings, we must knock 25 percent off the figure for physicians. Comparing $75,000 with $19,381—or $18,331, the most representative figure—we find physicians making roughly four times as much as nurses.

IF THE free market were working, the income differential between doctors and nurses would be just enough to assure a sufficient supply of the two professions. Reality, however, appears to conform with theory in neither case, for our nation faces not only a looming glut of doctors but an acute shortage of nurses.

Nursing publications estimate that 100,000 budgeted RN positions are going begging every year. The shortage is nationwide, affecting [illegible] percent of all medical institutions. The more desperate among them are paying bounty hunters, offering free cars and Hawaiian vacations, or providing housing, day care, and the like to lure nurses.

Poor pay is not the only reason for this shortage, apparently, and may not be even the primary reason. In most surveys nurses complain bitterly about their lack of authority and power within the medical hierarchy. Traditionally they have been treated as doctors' handmaidens, even being required to stand when a white-frocked physician entered the room. There are also problems of stress, overwork, irregular hours (the most acute shortages are normally on the night shift), and—perhaps equally important—an absence of significant channels for advancement.

If staff RNs want to advance in their profession, they cannot gradually be promoted to new levels within nursing. They must go into teaching or administration, fields with inherently limited job openings, neither of which has much to do with patient care, or go back to school and train for a year or two to become nurse-midwives, nurse-practitioners, or nurse-anesthetists. These specialties are still very small, their combined membership reaching only about 30,000 in 1980. For the average RN, there is little option but to tolerate the frustration

Ratio of average doctor's earnings to average male industrial worker's earnings during the 1970s, showing how most doctors are compensated.

United Kingdom	2.7	salary ↓
Sweden	3.6	
Ireland	3.6	
Denmark	3.8	
Belgium	5.3	fee-for-service ↓
United States	5.6	
West Germany	6.1	
Netherlands	6.4	
Italy	6.8	
France	7.0	

and boredom of an essentially dead-end job.

Such non-wage-related complaints don't explain away the nurse shortage. On the contrary; in a free market one of the functions of income differences is to compensate for such complaints by luring workers into unpleasant jobs with greater amounts of cash. Nurses' salaries have begun to rise in response to the shortage (50 percent in the last five years, from a 1977 average of only $13,000), but that has barely been enough to stay ahead of inflation and—more to the point—not enough to eliminate the shortage: In fact, according to the American Hospital Association, there are nearly 400,000 qualified registered nurses who have chosen not to work as nurses.

At the more affluent end of the health-care pay scale, the situation is exactly reversed. Doctors have gone from being too few in the 1960s to too many today. Thanks to an intense federal effort to finance an expansion of medical schools, the number of medical students more than doubled between 1960 and 1980. The total number of physicians rose from 259,000 to 447 000, with government predictions of 643,000 by the year 2000. According to the Graduate Medical Education National Advisory Committee (GMENAC), a high-level body set up under HEW to study the problem, the nation will have a surplus of 70,000 doctors by 1990 and 145,000 by the turn of the century.

Already there is a glut in some areas and specialties, with doctors beginning to recruit patients away from their colleagues and many areas recommending that new physicians go elsewhere. The surplus exists primarily in the highest-paid specialties, such as surgery—not surprising, perhaps, until you realize that in the theoretical market (and in other professions like engineering), high pay is a response to labor *shortage*, while oversupply of a given type of specialist is supposed to bring pay scales down until the surplus disappears. By 1990, GMENAC predicts, serious physician shortages will remain only in three of the lowest-paid branches of the profession—child psychiatry, general psychiatry, and preventive medicine—plus emergency medicine, a new field with a high rate of "burnout."

Doctors' incomes are losing pace in areas of oversupply, such as New England and the Middle Atlantic states, because patient visits per doctor are declining. But doctors' *fees* have not slowed or fallen, as they are supposed to during a glut. And the doctor glut, like the nurse shortage, shows no sign of disappearing.

WHY is it that doctors can make so much, and nurses so little, despite the supply imbalance? As anyone unlucky enough to have stayed in the hospital knows, nurses do valuable work, just like doctors. They too are professionals, investing an average of three years in their education and training. They often compare themselves to teachers, physical therapists, and pharmacists, yet they are paid far less.

On the nurses' end of the inequality, some of the answers are obvious. Nursing has always been considered women's work—traditionally poorly paid and, until recently, associated with a captive labor market. Women simply did not have hundreds of other career options, and once they became nurses they could not easily switch to other industries. Others who work in hospitals—computer technicians, managers, electricians, accountants, even pharmacists and physical therapists—can easily find work outside hospitals. Most nurses cannot. In small and medium-sized communities there are often only one or two hospitals, and again, traditionally the average woman has not been able to move from city to city or state to state quite as easily as the average man. Unions in nursing have been weak, in sharp contrast to the immense power of the doctors' union, the American Medical Association.

After a brief period when Medicare and Medicaid money set hospitals awash in federal funds, nurses' wages were depressed during the 1970s as pressure mounted on hospitals to contain soaring costs. Nurses' salaries account for at least 25 percent of hospital costs. Unable to control other expenses, such as energy, supplies, and salaries of physicians, hospitals tried assiduously to keep the lid on in the only place they could: nurses' wages.

Trying to explain doctors' incomes is a bit more puzzling. There are three common justifications for incomes in the doctors' range. First, they might be necessary to entice people into taking socially necessary risks. But this argument, while it may apply to oil drilling or starting silicon-chip factories, will not wash for medicine. It is not easy to get into medical school, but once there, a budding young doctor has as close to a sure thing as our society offers. Few people flunk out of med school these days, and even if one despises patients or faints at the sight of blood, one can always go into radiology or pathology and pull down an easy $100,000 a year. Risk is all but eliminated from the picture.

High salaries are also justified as compensation for bearing heavy responsibilities. This argument clearly has some validity when applied to physicians. Doctors do make life-and-death decisions, and surely that calls for some incentive. But nurses also bear a burden of responsibility. Does the difference really justify a four-to-one income ratio? The argument seems to fall flat when one realizes that two of the highest-paid medical specialties are those with the least responsibility for patients. They are radiology (in which on makes diagnoses for other doctor patients with X rays, ultrasound CAT scanners, and the like) an pathology (in which one examine cell specimens in a laboratory). Bo specialties have median income well above those of even surgeo and obstetricians.

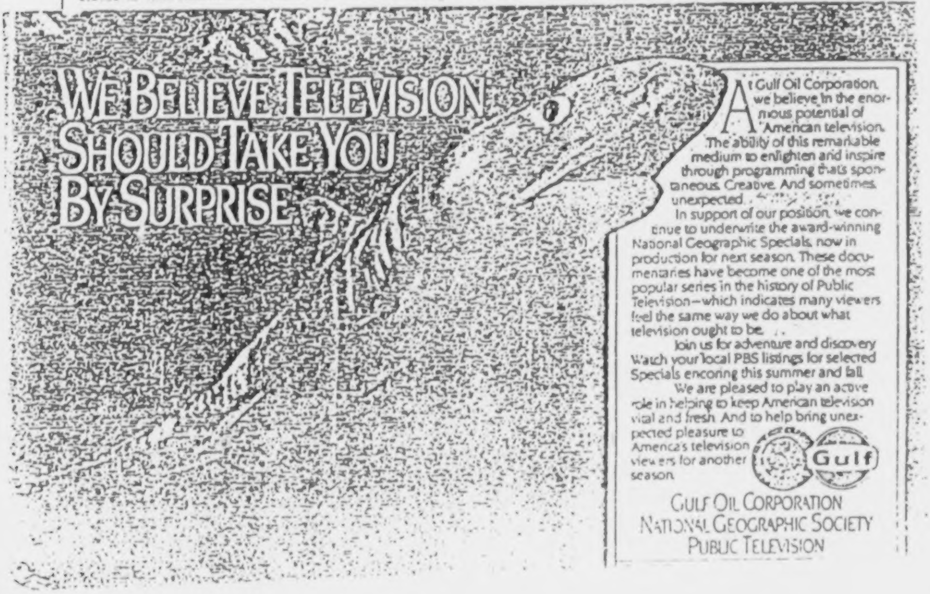
Finally, there is the justificati you will most often hear from doctors themselves: the long and expensive period of education a training necessary to enter medicine. Most American doctors have put in eight hard years of higher education, followed by three to five years of residency. In recent years most have racked up $20,000, $30,000, or even $50,000 in debts, depending on family finances and tuition levels. For most aspiring doctors, deferred gratification has become a way of life, often well into their thirties.

Having witnessed my own wife going through this process, I can testify that it has a tremendous impact. Students decide on medical school, in my experience, with little thought of financial reward. At age twenty there are many quicker, easier paths to wealth, including law school and business school. The medical initiation process—twelve years of grueling eighty-hour weeks, in which one grubs around in everything from cankers to cadavers—is simply too long to embark on for mercenary reasons. The motives of premeds certainly run the gamut—from longing for security and status to true fascination with medicine—but big money is rarely among them.

By the end of medical school, however, the picture has changed. Exhausted, deeply in debt, approaching their thirties, the new M.D.s have had it with deferred gratification. Visions of BMWs and Caribbean vacations dance in their heads. They want it bad, and most believe they deserve it. Unfortunately, they know the worst is yet to come. Depending on their specialty, they face three, four, or five years of sheer exhaustion, working 100 hours per week, doing without sleep every third night, and giving up any hope of a social life—all for four or five dollars an hour.

Looked at subjectively, then, and given the typical doctor's famine-feast cycle of reward, the problem may be understandable. By objective economic standards, however, it appears that doctors cash in to an extent hardly justified by any economic calculation. Doctors' debts seem staggering, until one realizes that nurses have debts left over from their training, too, and that the typical medical student's debts average out to less than $1,000 a year more than a typical nurse's, over an entire career. In fact, if you view medical school as an investment (of tuition and forgone earnings) by doctors in themselves, with the payoff being the difference between an M.D.'s and an ordinary college graduate's income, then the rate of return on that investment (judged by one 1970 study to be 22 percent) is roughly double the return on funds spent for a college education. In other words, even taking into account all the debts and deferred gratification, the doctors' implicit bargain turns out to be a very lucrative deal.

NEITHER supply, demand, risk, responsibility, training, nor deferred gratification seems to account for the huge disparity between doctors' and nurses' incomes. What does? To answer that question we must look to forces that have nothing to do with the classic free market.



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more moderately priced nurses.

To balance the institutional power of the hospitals where most of them work, nurses also need stronger unions. This is a step some might fear, knowing the destructive effect of public-sector strikes and the tendency of many unions to use their power to protect incompetents and enforce rigid work rules. But even hospital workers can strike responsibly (by not striking in intensive care units, for example). As for protecting incompetents, it is typically those unions with no power to strike over wages, such as many government-employee unions, that spend their greatest efforts attempting to serve their members by erecting rigid barriers against discipline or dismissal.

THERE are several strategies for keeping physicians' salaries down (which would, in turn, keep overall medical costs down, since physicians currently receive a fifth of all money spent on health care). First are steps to restore as free a market as possible, such as promoting advertising to spur price competition among doctors, and breaking down the guild practices that restrict lower-cost, non-M.D. competitors. Second, reform of medical education and training to make it less expensive and grueling, and perhaps shorter, would surely mute the subsequent greed of graduates. Instead of making students borrow $50,000 for tuition alone, why not simply tax them a flat, fixed percentage of their income after graduation (so those with the highest future incomes would pay the most)? The percentage could be set to raise the same amount of money as the current system, but the psychological impact would be very different. Similarly, it is surely a false economy to make residents work for four dollars an hour if that only fuels their desire to cash in big later.

A more important step would be to reduce directly doctors' fees in the vast majority of cases where some form of insurance is involved. The strategy currently favored by the Reagan administration is to increase the share paid out-of-pocket by consumers, to make them more sensitive to price. But, as discussed above, the very nature of medical care discourages effective price shopping; if the consumer's share were made large enough to force price consciousness, it would probably be so large as to defeat the very purpose of insurance.

A better strategy would be to take more advantage of the institutional power of large insurers. For example, since Medicare and Medicaid provide 21 percent of all physicians' fees, the government can wield a certain amount of influence in forcing prices down. Some 70 or 80 percent of all doctors currently accept Medicare and/or Medicaid patients. If they were confronted with lower reimbursement levels and banned from billing patients for additional amounts (which many Medicare doctors now do), some would flatly refuse to take government-insured cases. But many would have no choice but to accept. The medical profession would scream about "socialized medicine," but in fact the government would be doing nothing more than acting as an intelligent capitalist—paying as little as possible for the services it buys. After all, when the government buys steel and concrete for a road we expect it to shop for the best price. Why not when it buys medical care?

Private insurers and large employers should be encouraged, or required, to do the same thing. The U.S. today is the only developed Western nation in which private insurance reimbursement levels are not limited in some way by the government.

Experience in other countries shows that the most effective arrangement is a united organization of all private and government insurers to negotiate fee schedules with the doctors so they cannot play one insurer off against another. Unfortunately, however, overseas experience also shows that defeating the organized power of doctors requires extraordinary political will and strength. Charles de Gaulle had to resort to emergency powers to bring French doctors into line in 1960. Needless to say, this sort of political will has not been shown by the Reagan administration, which has proposed only a feeble 2 percent cutback in reimbursement rates for Medicare payments to hospitals—but not to doctors.

Finally, health-care reform must address the fee-for-service concept itself. The clearest lesson to be drawn from the rest of the world's health-care experience is that the way to restrain physicians' incomes is to get them off fee-for-service and onto straight salaries. In those west European nations where all or many physicians were on salary during the 1970s—Great Britain, Sweden, Ireland, and Denmark—the ratio of physicians' total incomes to those of male industrial workers was below four to one. Nations with fee-for-service arrangements (including the U.S.) had ratios of 5.3 and up, despite the fact that most had national health insurance, in which the government bargained over fee schedules. The reason is already familiar: when doctors can bill for each service performed, they can simply bill for more services, even when their fees are controlled. When they are on salary, they have no such option.

In the U.S., only 10 percent of patient-care physicians (excluding residents) receive a salary. Obviously, the quickest way to change that would be through a national health-care system in which all doctors work for the government. This is the British model, which has produced the lowest physician-to-industrial-worker income ratio in western Europe, 2.7 to one.

An arrangement more in keeping with the spirit of American capitalism is the health maintenance organization (HMO). HMOs typically put doctors on salary. Moreover, because they charge consumers only a flat monthly fee for all their medical needs, they allow consumers to price-shop, and to do their shopping when they are well rather than sick. HMOs offer customers the benefits of health insurance without its cost-inflating disadvantages. Forced to compete for

The fact is, a working free marct simply does not exist in the ealth-care sector (as the persistence of glut and shortage itself sugests). The most obvious nonmaret force is the guildlike power of he American Medical Association. From the 1930s through the 1960s, he AMA deliberately fought to limt the number of physicians pracicing in the U.S. During the 1930s his was accomplished by forcing medical schools to reduce their ranks. After World War II it was done by fighting federal aid to medical education. As the AMA warned of a coming physician surplus, the ratio of doctors to the overall population actually *fell* between 1950 and 1960.

During this entire period, doctors' incomes rose rapidly. In 1929 they were in the same league with those of lawyers and dentists, and in 1945 they were three times as high as nurses' salaries (per year, not per hour). Today physicians make more than five times what nurses make annually, and twice what lawyers and dentists average.

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The AMA also fought hard to push out its competition at the state and county levels: osteopaths, chiropractors, midwives, and even health maintenance organizations (HMOs), whose patients pay a set monthly fee for all their medical care. Even today the association is working in state legislatures and local hospitals to keep nurse-practitioners, nurse-midwives, and physicians' assistants from performing certain routine procedures and prescribing medicine. As a result, we have few alternatives to seeing an M.D. when we are ill.

Luckily for doctors, by the time the AMA-created shortage had become so acute that Washington had to do something about it, another factor was already at work to ensure steadily rising incomes. This was the rapid growth of third-party payments: health insurance, Medicare (for the elderly), and Medicaid (for the poor). Private insurance became commonplace between 1945 and 1965, while the federal programs came on line in 1966. Today 90 percent of Americans have some form of coverage, and almost two thirds of all physicians' services are paid for by third parties, most of which fix payments to doctors in accordance with their customary fees.

This system has had predictable and well-known effects. Because the customer—the patient—is rarely paying for his own medical services (the way he would pay for a toaster or new car), he has little incentive to hold down the cost of his own treatment. With most patients insured, doctors can charge them top-drawer rates, or perform procedures of questionable necessity, without worrying about losing business, the way other sellers do.

Even if everyone did pay for his own medical care, "the market" would not work to hold down doctors' fees as it does in other industries. Several of the ordinary conditions that facilitate rational consumer choice simply do not exist in health care. First, most patients are ill when the time comes to choose what health care to buy, and they are not inclined to shop around or question a doctor's judgment. Nor are they likely to have the information necessary to question it. As laymen, without the slightest idea of what an intravenous pyelogram is (much less whether they need it), they tend to let the white-coated experts make the decisions. The typical medical consumer is like the shopper who goes to a clothing store in desperation, states the problem ("I need a dress for the prom"), and lets the sales clerk decide what she should buy and at what price.

MEDICAL institutions do not make it easy for consumers to shop for lower prices. You don't find hospitals giving sales on nose jobs or gall-bladder operations. The AMA ban on doctor advertising (which the Federal Trade Commission has ruled illegal, but which the AMA is fighting to preserve in the courts) effectively inhibits any consumer impulse to go comparison shopping. But the point is that even if these hurdles were removed, the nature and timing of medical decisions would make it difficult for the free-market forces to set fees (and hence incomes) in this industry.

The few exceptions illustrate the rule. Consider eyeglasses and drugs —items that lend themselves to price shopping, which are not always purchased when one is ill, which are not normally covered by insurance, and which, in the case of eyeglasses, are subject to price advertising. Neither has followed hospital and physician services up the price escalator. While the total amount spent on hospital and physician services almost doubled between 1972 and 1977, the amount spent on drugs increased by only a third, while that spent on eyeglasses barely rose at all.

Conventional market forces are so weak in medicine, in fact, that in areas where there are too many physicians and where competition should lower fees, just the opposite happens. Economists have developed a theory to explain this. Called the "target-income hypothesis," it observes that when faced with fewer patients per physician, doctors raise fees and/or perform more services per patient—enough to bring their incomes up to their personal "targets" and finance the comfortable lives they've come to expect. Boston has six times as many doctors per capita as northeast Arkansas, for example, but routine specialist charges and Medicare payments per patient are 70 percent higher in Boston. Research from Canada and West Germany, as well as the U.S., shows that doctors have reacted to wage and price controls by performing more services per patient, thus evading the intent of the controls.

LET US briefly indulge the suspicion that society would be better off if doctors made less money and nurses more (particularly in light of the current supply imbalance between the two professions). To risk proposing concrete figures, suppose we wanted nurses to make $30,000 a year and doctors to make merely twice that. How might it be done?

The most desirable way to raise nurses' incomes would be to increase the number of nurse-practitioners and nurse-midwives. Nurses might be encouraged to set up their own practices, allowed to receive third-party payments, and generally treated more like general practitioners. This would require increased training, which would be built more directly into the nursing career ladder so that RNs could make at least partial progress toward nurse-practitioner status while continuing their work—and so that nurses wouldn't simply follow the lead of doctors by establishing credential barriers against those LPNs and assistants below them in the health hierarchy. The doctors, of course, are not about to cede any of their territory without a fight, particularly with a glut of physicians staring them in the face. But the benefits certainly justify fighting back. For nurses they include a realistic chance of advancement and financial reward; for consumers, a chance to have many services that now must be performed by high-priced doctors performed by

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customers, HMOs must keep the quality of care up while minimizing unnecessary services in order to keep costs down.

HMOs could even provide an old-fashioned free-market way for doctors to get rich—not by charging high fees, or performing unnecessary services, but by collectively (or even singly) owning the HMOs for which they worked. Such doctor-owners would get rich the same way other businessmen (ideally) get rich—if their businesses attracted customers by providing the right combination of quality and cost, and advertised those virtues effectively. The doctor-owners who started an HMO would be taking a risk, just like entrepreneurs in other industries—and these risks, and the skilled work necessary to overcome them, are precisely what would justify the hefty incomes they'd get if they succeeded. In the best of all possible worlds, HMOs might even be owned collectively by the doctors, nurses, and others who staffed them, so everyone could get rich, or relatively so.

The HMO scenario is appealing, particularly to economists, because it holds out the possibility of recapturing some of the competitive benefits of the marketplace. But its flaw is obvious: as long as HMOs must compete for doctors with the lure of unrestricted private fees, economic incentives will pull the best doctors toward private practice and stigmatize HMOs as second-rate health care. This is why the government must simultaneously act vigorously to keep private physicians' fees under control by limiting third-party payments.

To the current administration, of course, any mention of using the government to limit doctors' fees—even if only through the government's own influence as a health-care insurer—smacks of tampering with the free market. But in medicine there is no free market, and in important respects there never can be. The sooner the government recognizes that fact, the sooner there will be fewer overpaid doctors and a sufficient number of adequately paid nurses. And the sooner we can all afford to get sick again. ■

THE $310 MILLION PARANOIA SUBSIDY

by Patrick Brogan

All those X-ray machines are a waste of money.

By now, we are all used to the indignity of being searched at airports. Since 1972, when President Nixon ordered the Federal Aviation Authority's security program, our bags have gone through one machine, our bodies through another, while bored "screeners" glance at images of our laundry or nag us about keys in our pockets. Airport security has become just another part of the disagreeable pattern of late-twentieth-century living, to be endured as we do unopenable aspirin bottles or garbage in the streets.

But is it necessary, or even effective? Last year, at a cost of $260 million, 15,000 security personnel and police at 379 American airports foiled eight would-be hijackers. Six

Patrick Brogan, former Washington correspondent of The Times (London), is a freelance journalist living in New York.

Exhibit III

Nurse Anesthetist Training Proposal

from the

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

1. Amend Nurse Training Act, Section 831 of NTA (42 USC Section 297-1) to:

   (a) Strike Section 831(b) and substitute:

   "(b) The Secretary may also make grants to public or private non-profit entities to cover the cost of projects to improve and upgrade existing programs for the education of nurse anesthetists which are accredited by an entity or entities designated by the Secretary of Education including grants to such entities for the purpose of providing financial assistance and support to certified registered nurse anesthetists who are faculty members of accredited programs to enable them to obtain advanced education relevant to their teaching functions."

   "(c) For the purpose of making grants under subsections (a) and (b), there are authorized to be appropriated $1.2 million for fiscal year 1985, $2.2 million for FY 1986 and $3 million for FY 1987."

American
Dental
Association

ADA

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March 23, 1984

The Honorable Orrin G. Hatch
Chairman, Committee on Labor and Human Resources
United States Senate
135 Senate Russell Office Building
Washington, D.C. 20510

Dear Chairman Hatch:

I am writing to express the views of the American Dental Association on the pending reauthorization of the Health Professions Educational Assistance Act.

Student Assistance

The American Dental Association believes that a comprehensive and financially viable program of health professions student aid should be accorded a top priority in a renewal of the health manpower law. Our position on this issue is prompted by the high cost of dental education and the impact of this cost on student indebtedness and the changing socio-economic profile of dental students.

The cost of graduate education has increased dramatically in recent years. Nowhere is this trend more evident than in the 60 U.S. dental schools where the average tuition has risen more than 250 percent in the past decade. Today, the average first-year cost to the dental student, exclusive of living expenses, is approximately $10,000. Total four year costs exceed $32,000, and range as high as $64,000 at some institutions.

An immediate consequence of this high cost of attending dental schools is the escalating debt burden of recent dental graduates. Current data indicates that a sizeable majority of the more than 22,000 dental students are forced to rely heavily on loans to finance their professional education. In 1978, graduating dental students reported total educational debts averaging $12,700. By 1983, this amount had risen to almost $29,000. It is not unusual for students at private schools to incur debts exceeding $50,000. Equally disturbing is the sharp increase in the percentage of dental students who have exhausted available loans under the more favorable GSL and HPSL programs and must turn to high interest rate HEAL loans. In 1979, 5.8 percent of senior dental students reported loans borrowed under the HEAL Authority. This figure has since reached 21.4 percent for 1983 dental graduates.

There is a legitimate concern, we believe, that these highly indebted graduates will not have the financial ability to repay loans of this magnitude during the early years of dental practice. The most recent ADA "Survey of Dental Practice" indicates that a dentist who graduated in 1981 had a median net income of $27,000 during the first year of practice. With the additional cost burden of establishing a practice, in this instance approximately $90-100,000, it is possible that graduates may anticipate four years of practice with virtually no discretionary income following taxes and loan repayments.

A second consequence of this rapidly increasing cost of education is the changing socio-economic profile of the dental student body. In 1978, 37 percent of senior dental students were from families with annual incomes below $20,000. By 1983 this figure had decreased to 18 percent. Conversely, the same study reflects a significant increase in the number of students from higher income families. The percentage of senior students from families with incomes greater than $40,000 was 22 percent in 1978. By 1983 this level had doubled to 44 percent.

In conclusion, the Association urges Congress to act positively in addressing these issues by insuring (1) that individuals without adequate financial resources are afforded an opportunity to pursue a career in the health professions, and (2) that students are not forced to incur an unmanageable debt in order to obtain a health professions education. This can be accomplished, in part, we believe, by extending the Health Professions Student Loan program with increased federal capitalizations and by expanding the scope of the Exceptional Financial Need Scholarship authority. Additional federal capital contributions are needed for the HPSL program in order to increase the loan capacity at those schools with an unusually high percentage of needy students, and for those institutions which have underdeveloped loan revolving funds as a result of their more limited period of operation. The Exceptional Financial Need Scholarship program, at current funding levels, is able to assist only one student per institution. Moreover, such scholarships are limited to one year of support. We strongly believe that the EFN authority should be significantly expanded and that eligible students be assisted by those scholarships for their full four years of undergraduate health professions training.

General Dentistry Training

The current law, Section 786, authorizes federal support for dental general practice residency (GPR) training. These programs have been particularly effective in providing future practitioners with the skills and experiences necessary for the provision of comprehensive, primary care to medically and emotionally compromised patients. Unfortunately, a decline in funds available for grant awards has sharply reduced the number of GPR projects which can be supported. During the current review cycle, for example, the Department of Health and Human Services has received 60 applications requesting more than $8 million to provide training experience for 290 general dentistry residents. However less than $1.9 million is available for dental GPR project grant awards. This compares to $4.5 million which was awarded under the program in fiscal 1978.

The reduction in federal support for the GPR program is occurring at a time when the demand for additional training in general dentistry is increasing markedly. Over 2,000 graduating senior dentists are expected to seek advanced training in general dentistry in 1984 with less than 850 educational opportunities available.

As a partial response to this demand, new, non-hospital based advanced general dentistry programs have been developed. These programs are designed to provide a wide experience in clinical dentistry and oral health care. However, a lack of federal funds and the economic constraints affecting higher education have slowed the growth of these programs.

The American Dental Association believes that both the hospital based GPR experience and the new advanced general dentistry programs are an important resource in producing a broadly competent general practitioner. The current language in Section 786 is, however, overly restrictive by the use of the term "residency" in describing eligible general dentistry training activities. This designation fails to recognize and include the new, non-hospital based programs noted earlier. The Association will submit, for the consideration of the Committee, appropriate amending language to clarify this issue. Secondly, the Association believes that the absence of a percentage set aside for the funding of general dentistry training, within the total authorization for Section 786, has created unnecessary competition with Family Medicine programs during the appropriations process. The original statutes did in fact stipulate that a certain percentage of the amounts

The Honorable Orrin G. Hatch
March 23, 1984
Page 4

appropriated under this authority were to be made available for general dentistry. We believe this is a sound and equitable approach. An earmarking of 15 percent for general dentistry training is therefore recommended. Finally, the Association urges the Committee to restore the overall authorization for Section 786 to a level approaching that of prior years. An annual sum of at least $42 million is recommended.

The American Dental Association respectfully requests the inclusion of this statement within the official hearing record.

Sincerely,

James P. Kerrigan

James P. Kerrigan, D.D.S.
Chairman
Council on Legislation

JPK:nj

American Hospital Association

AHA

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
ON REAUTHORIZATION OF THE HEALTH PROFESSIONS
AND NURSING EDUCATION PROGRAMS
S.2301-- HEALTH SERVICES, PREVENTIVE HEALTH SERVICES AND
HOME AND COMMUNITY-BASED SERVICES ACT OF 1984
S.2303--ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH
SERVICES BLOCK GRANT AMENDMENTS of 1984

March 26, 1984

The American Hospital Association, which represents approximately 6,300 institutions and more than 35,000 personal members, is pleased to have this opportunity to submit its comments on the reauthorization of health manpower and nurse training programs under the Public Health Service Act. We also would like to present our views on two additional pieces of legislation within the purview of the Labor and Human Resources Committee--S.2301, the Health Services, Preventive Health Services and Home and Comunity-Based Services Act of 1984; and S.2303, the Alcohol and Drug Abuse and Mental Health Service Block Grant Amendments of 1984.

Health Professions and Nursing Education Programs

As employers and educators of health care personnel, hospitals are deeply concerned about the federal manpower policy. To fulfill their commitment to deliver high quality care, hospitals need an adequate supply of qualified professionals and competent technical personnel. Moreover, hospitals directly are involved in all levels of health personnel training: they participate in the clinical aspect of graduate and undergraduate medical education; they operate hospital-based schools of nursing; and they offer clinical experience to undergraduate and advanced students in collegiate programs. They also sponsor or are affiliated with a full spectrum of allied health education programs.

Since the early 1960s, the Health Professions Education and Nurse Training Acts have provided substantial federal support for health manpower training. For the most part, these programs have been successful in alleviating severe shortages of trained hospital personnel. Indeed, reports of an impending physician surplus and of a doubling of the nation's supply of registered nurses over the past two decades indicate the program's success. Although numerical shortages of personnel no longer may be severe problems remain with the quality of training and the geographic and specialty distributions among trained personnel. Furthermore, competent young people are being turned away from health careers by financial barriers, while some are finding themselves locked into rigid job categories and denied avenues of career advancement. As a matter of public policy, we should not allow this trend to continue.

The ever-increasing demands for skilled personnel make a comprehensive manpower policy more necessary than ever. Technological advances are creating new occupations each year, while making some old ones obsolete. At a time when federal reimbursement and utilization control policies are encouraging shorter lengths of stay and greater use of outpatient services, hospitals are being called upon to provide more intensive services to a greater proportion of acutely ill patients. Medicare's prospective pricing system undoubtedly will place additional demands on hospital personnel as incentives for cost-effective management have to be reconciled with the continuing responsibility to deliver quality care. Trained administrators will be required in all areas of hospital operations--financial and records management, as well as patient care management and service delivery. Furthermore, hospital personnel will need to be cross-trained or retrained, and their competence evaluated as hospital administrators look to deploy their staff efficiently, especially in smaller hospitals where one person may be required to perform several technical functions.

For these reasons, the AHA believes that the federal government should maintain its basic commitment to Titles VII and VIII, while adjusting priorities within those authorities to meet changing hospitals' needs. We agree with the Administration that it is unwise indiscriminately to continue subsidizing training in the face of personnel surpluses; it is unfair to those undergoing training, and it jeopardizes the livelihood of those already in the occupation. But today's surplus may be tomorrow's shortage, as demographic changes occur and prospective students react to marketplace conditions. We support aspects of the Administration's fiscal 1985 budget proposals. Student loan programs should be financially viable and minority and disadvantaged students should be targeted for financial assistance. The AHA also believes the authorities for "special projects" offer useful mechanisms for conducting experiments in curriculum development, assurance of competency, and manpower utilization. But the Administration's budget also proposes drastic cutbacks in funds for health professions and nurse training programs. The cuts not only would jeorpardize the stability of our educational institutions at a time when they already are financially stressed, but also they would prove to be counter-productive in the long run. We suggest that a more positive approach would include:

o Keeping the existing authorities open, but making them more flexible to allow support for training of a full range of professional and technical people to meet evolving marketplace demands; and

o Shifting the focus of government attention away from the training of additional health manpower and toward research on ways of using that manpower more cost-effectively.

The Congressional Record summary of the health professions education proposal indicates that membership on the National Advisory Council on Health Professions Education might be expanded to include a representative of an allied health professions education program. We suggest that a hospital representative also be included on the Council to voice providers' concerns regarding professional education.

We will address our specific comments to the outlines of Senator Hatch's health professions and nurse training reauthorizations as published in the

March 13 Congressional Record. In addition, we would appreciate the opportunity to offer additional comments when the measure is introduced. We will consider separately the three major areas of medical education, nurse training, and allied health education.

I. Medical Education

As Senator Hatch has noted, the 1981 report of the Graduate Medical Education Advisory Committee (GMENAC) suggests that though there may be a surfeit of physicians by 1990, there will be an ongoing need for primary care physicians, rehabilitation specialists, and preventive and public health experts. Therefore, special projects grants programs for these areas should be maintained [Sec.788]. The proposal to redefine the program for training physicians' assistants [Sec.701(8)(A)] to focus on these fields also deserves support.

The rapidly escalating cost of a medical education is creating an untenable situation. Students from all but the wealthiest families increasingly are discouraged from assuming an enormous burden of debt, and graduates, in order to pay their debts, are forced to enter the more remunerative specialties, thus leaving primary and preventive care areas undersupplied. Affordable loans, realistic pay-back schedules, and a responsible debt collection policy to ensure that loans are available for future students are necessary components of manpower legislation.

In addition, a loan forgiveness provision to encourage physicians to practice in underserved areas should be part of the measure. Consequently, we support the extension of the authority for the Health Professions Student Loan Program through 1991 and ask that its loan forgiveness provisions be retained [Sec.743]. We also advocate reform of the debt collection system. Moreover, to encourage minority and disadvantaged students to begin medical careers, we urge renewal--at enhanced levels--of the Exceptional Financial Need (EFN) scholarship program and the Disadvantaged Assistance program.

II. Nursing Education

Nurses are key figures in any hospital, and they are assuming more responsibility in today's hospitals. Prospective pricing will make their patient care management activities crucial. Though the supply of nurses has increased, shortages persist in certain geographic areas and in specialities such as intensive and neonatal care. Nurse training is a priority issue to the AHA. Any profession develops as its knowledge-base expands and as its leaders have the opportunity to develop their own skills, to define the profession's scope, and to explore new ways of accomplishing its goals. The nursing profession is seeking to strengthen its leadership through programs of advanced nursing education and nursing research. We represent approximately 245 hospital schools of nursing as well as more than 3,500 members in the

AHA-affiliated American Society for Nursing Service Administrators. The Association urges reauthorization of the Nurse Training Act at levels that will facilitate hospitals' efforts to train and obtain competent nurses at all levels. The Administration's proposal to cut funding to one-fourth of last year's level and to eliminate funding of traineeships and fellowships cannot be justified. We urge you to keep funding at least at the Fiscal Year 1984 level.

Our system of nursing education is diverse, and this diversity should be encouraged through federal support given to nurse training regardless of setting. Scholarships, traineeships and research grants should be open to students in hospital schools of nursing as well as those in collegiate programs. Specifically, the nurse practitioners' program [Sec.822] and the special demonstration projects authority [Sec.820] should be broadened because not all nurse practitioner training occurs at the collegiate level. In addition, the current policy that makes all "public or nonprofit institutions" eligible for nursing traineeships is preferable to the proposed amendment which would restrict eligibility to schools of nursing [Sec.830].

As with physician training, access to careers in nursing by disadvantaged individuals and minority group members should be facilitated. But Senator Hatch's proposal inappropriately would delete the preference given to licensed practical nurses (LPNs)--who most frequently come from the neediest economic groups--in the student loan program [Sec.836]. Furthermore, LPNs already have demonstrated their commitment to a career in nursing and, indeed, may be deserving of preference.

To enhance nurses' job satisfaction and to encourage them to remain in their profession, paths to career development must opened up, not blocked by institutional and credentialling barriers. Therefore, the AHA endorses federal efforts to encourage cooperative arrangements between hospital-based nursing programs and academic institutions. The special projects authority [Sec.820] is potentially useful for this purpose. We also support efforts to make retraining programs and continuing education opportunities available to nurses, LPNs, and nurses aides. Moreover, nursing research oriented to "the promotion of health prevention of illness, and understanding of human response of individuals and families to acute and chronic illness and the aging process" would be beneficial.

Nursing research and advanced nursing education funding need not be restricted to masters' and doctors' level programs. If completion of a certificate program qualifies a nurse as a nurse practitioner in her state, there is little reason to make traineeship funds unavailable to her [Sec.830]. The current provision regarding advanced nurse training programs is preferable to the more restrictive proposed amendment [Sec.822]. The proposed section inappropriately would restrict nurse practitioner programs to the master's level.

III. Allied Health Personnel

The AHA supports reauthorization of student financial assistance programs. Chairman Hatch's proposed manpower bill, however, would redefine "allied health professional" to include education beyond the undergraduate level without consideration of an allied's training, responsibility, or experience levels. From hospitals' perspective, everyday experience is a more important factor than simply possessing an academic degree. Consequently, alternative methods of determining allied health professionals' competency might prove a useful area for study under the special projects grant authority.

Funding for allied health education programs within community hospitals as well as colleges, teaching hospitals, and medical schools, should continue. Clinical facilities also must be made accessible to minority and disadvantaged students who are unlikely to seek training in medical school-based programs.

Current economic conditions, shrinking federal funding levels, increasing education costs and the unmet needs of minority and disadvantaged students all reinforce the view that student financial assistance should not be available only at the post-graduate level. The AHA recommends continued financial support for health management and allied personnel education programs with emphasis on funding priorities based on marketplace needs.

S.2301 - Health Services, Preventive Health Services and Home and Community-Based Services Act of 1984

S.2301 would reauthorize the preventive health and health services block grant, and the separate tuberculosis, venereal disease, and immunization programs. It also would authorize a new home and community-based health services block grant and a three-year demonstration project related to improving emergency medical services for children.

The AHA endorses the reauthorization of the preventive health and health services block grant as well as the tuberculosis, venereal disease and immunization categorical grant programs. We believe that federal funds spent on health promotion and disease prevention are cost-effective investments in improved health and prolonged life.

The AHA has increased its own support to the areas of health promotion and disease prevention and, through our Center for Health Promotion, encourages and assists hospitals in expanding their programs in patient education, community health education and employee health programs. One of the many activities in which the Center has been involved was the development and dissemination of a packet of materials to encourage measles immunizaton, as well as other programs on topics such as smoking cessation, high blood pressure and early childhood immunizations. The information on measles was formulated in conjunction with the Centers for Disease Control's immunization division. The AHA is convinced, and the data supports the premise, that immunizing against preventable childhood diseases and altering some debilitating life styles ultimately will result in better general health and a reduction in unnecessary use of the health care system. It is a goal with a high benefit payoff.

The AHA supports Section 8 of S.2301, which provides demonstration authority for emergency health care for children. Our Association long has been involved in efforts to improve emergency medical services and has encouraged hospitals to play a key role in the development of comprehensive and integrated systems. Although the EMS program has been successful in reducing the annual number of trauma-related deaths, we agree that more attention now should be directed toward the emergency needs of critically ill children. It has been estimated that children comprise 20 to 35 percent of the nation's hospital emergency room patients, yet few programs exist to address the special needs--physical and psychological--of children in a critical care situation. We commend both Chairman Hatch and Senator Inouye, through the introduction of S.163, for bringing this issue to the Committee's attention.

S.2301 would create, within the prevention block grant, a Home and Community-Based Health Services Block Grant. The AHA supports this new authority as well as the continuation of existing authority for home health care training. Our Association is committed to increasing the scope of cost-effective, community-based health services for the elderly and chronically ill who are at risk of institutionalization. Such services can contribute significantly to the health and well-being of patients by restoring them to health or maximum function, reducing incentives for inappropriate admissions to institutions, and making possible earlier discharges from institutions. We also support those provisions of the bill that allow block grant fund reimbursements for "patient and family training, which may be appropriate and necessary to prevent the institutionalization of an elderly or a disabled individual." As ambulatory care programs are expanded, patients and their families will recognize that complicated care does not always require hospitalization. Since the advent of Medicare's prospective pricing system, hospital lengths of stay have been declining. It is expected that patients discharged from the hospital will be released with more complicated care plans. Education makes early discharge and self-care possible. Therefore, such education services should be expanded to ensure that patients, families, and/or caretakers can follow through with treatment protocols.

S.2303 - Alcohol and Drug Abuse and Mental Health Services Block Grant Amendments of 1984

S.2303 would reauthorize the Alcohol and Drug Abuse and Mental Health Services Block Grant (ADM) for Fiscal Years 1985 through 1987 and would include, among other provisions, a $7 million authorization for demonstration projects on alcoholism treatment and prevention efforts directed at women.

Although the American Hospital Association supports the goals of the ADM block grant, we believe the proposed authorization levels--$472.3 million in FY 85,

$486.5 million in FY 86, and $501.1 million in FY 87--are inadequate. The proposed FY 85 authorization is a 2-percent increase over FY 84 appropriation levels and actually represents a decrease in purchasing power after inflation. Moreover, though authorization levels included in the Omnibus Reconciliation Act of 1981, P.L.97-35, were intended to be appropriation levels during each of the three years of the ADM block grant, appropriations for the program have never reached those levels. The economic costs and the impact on society of alcoholism, drug abuse, and mental illness should be recognized since the cost of not treating these illnesses is exhorbitant.

Section 10 of S.2303 would authorize a special demonstration for the prevention and treatment of alcoholism, alcohol abuse, and drug abuse among women. The AHA commends the chairman for addressing the problem of alcoholism and drug abuse among women in our society, but we are concerned that the authorization level suggested for this demonstration will not be adequate to fund the wide range of services proposed in the bill. Additionally, there are many other segments of the population with unique needs which could benefit from special programs. For example, scores of homeless mentally ill and individuals suffering from alcoholism and other chemical substance dependencies have placed increased demands on the treatment system, particularly hospital emergency rooms. These groups often perceive the hospital as the only available source of care and could benefit from a program which focuses attention on their particular needs.

The AHA also is concerned about a measure in the ADM block grant that would prohibit the use of block grant funds for the provision of inpatient services. This blanket restriction on the use of funds curtails the availability of needed health care services under the block grant cited for mentally ill and substance abuse patients. Furthermore, it effectively impedes the continued development of community-based comprehensive care under the community mental health center program (CMHC) and the alcohol abuse and drug abuse treatment programs.

The programs consolidated in the ADM block grant were established to provide community-based comprehensive services for the mentally ill and substance abusers. One of the goals of the CMHC program is to provide alternatives to long-term institutionalization so that impaired persons could maintain themselves in the community. To provide this comprehensive care, the CMHC statute requires centers to have referral arrangements with hospitals, so that patients can be hospitalized if necessary.

A prohibition on the use of funds for inpatient services would severely limit the ability of the health care professional in outpatient centers to respond to patients in need of acute care. Sound medical practice dictates that inpatient care must be available and utilized when necessary. All mental and substance abuse problems neither can nor should be handled on an outpatient basis alone. It is the responsibility of the physician to prescribe inpatient carc where appropriate, as in crisis situations or when the patient may harm himself or others. The inability to use federal funds to pay for inpatient care, leaves CMHCs without workable referral arrangements with hospitals.

Finally, the ability of recently deinstitutionalized patients to be maintained in the community also could be jeopardized. Support services are necessary to prevent these patients from being sent back to state or county mental institutions. From time to time in a crisis situation, such patients may require short-term inpatient services. But, since such short-term inpatient services would not be available through the proposed CMHC program, the patient and community may have no other recourse than to recommend reinstitutionalization, which is contrary to one of the goals of the program.

We appreciate the opportunity to present our views on the manpower and nurse training reauthorizations and on proposals S.2301 and S.2303. The AHA would be pleased to provide any additional information you or your staff might require regarding the changes we have proposed.

STATEMENT

OF

THE AMERICAN PHYSICAL THERAPY ASSOCIATION

ON

HEALTH PROFESSIONS EDUCATION ASSISTANCE ACT REAUTHORIZATION

SUBMITTED TO

COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

FEBURARY 8, 1984

The American Physical Therapy Association (APTA) takes this opportunity to share with the Labor and Human Resources Committee Members our desire for broader Public Health Service Act support for educational opportunities for students of physical therapy and other allied health professions.

APTA is a national organization representing a membership of approximately 40,000 physical therapists, physical therapist assistants, and students. Physical therapists are licensed health professionals who practice in a wide variety of health settings. These professionals plan and directly administer physical therapy treatment programs to restore function, relieve pain, and prevent disability following disease, injury or loss of body part. Physical therapists must have completed at least a baccalaureate degree program in a college or university. In many cases, the physical therapy educational programs are housed in colleges of health sciences also know as schools of allied health within the college campus.

Allied health professionals, an umbrella term which encompasses physical therapists and many other health-related disciplines, constitute nearly two-thirds of the nation's health care workforce. However, their educational institutions have been accorded a mere four percent of total federal investment in Health Resources and Services Administration-funded manpower training and development. By 1982, funding through the Bureau of Health Professions for allied health programs decreased to zero. This reduction has caused difficulties for many allied health programs, and due to reduced slots for faculty and students, has exacerbated the problem of shortages of professionals, such as physical therapists, who are in high demand.

We were pleased to learn, however, that for 1983, Congress, in an appropriations measure, mandated new initiatives under Section 788 of the Public Health Service Act as amended relative to health promotion/ disease prevention and geriatric centers for which allied health schools could apply. However, Congress appropriated only $2 million of the $6 million authorized for this Special Initiatives venture.

Special Initiatives and Aid to the Disadvantaged are the only sections of the Act which offer support for allied health programs, but allied health programs must compete for the grants with education programs for dentists, podiatrists, optometrists, veterinarians, doctors and pharmacists. This is inequitable in view of the fact that these other health professions education programs are eligible for relatively high levels of support in each of the other titles of the Act. We therefore ask the Committee to rewrite Special Initiatives to more equitably support initiatives in allied health education.

In addition, we urge that all titles of the Act having to do with assistance to students be expanded to include schools and students of allied health. Students of physical therapy and most other allied health professions are excluded from applying for loans and grants under this Act. Eligibility for the Health Education Assistance Loan (HEAL) Program and the Health Professions Student Loan (HSPL) program, and the Exceptional Financial Need Scholarships has been limited to those studying: medicine, optometry, dentistry, veterinary medicine, osteopathic medicine, podiatry and pharmacy. Furthermore, in 1981, the Act was amended to enable students of chiropractic medicine, health administration and graduate students of clinical psychology to apply for federally insured loans.

Similarly, before the programs were cut from the Act in 1981, allied health educational programs were ineligible to apply for construction grants and start-up grants. Allied health programs have had to rely on tuition revenues for their existence and growth.

We request that eligibility for these loan programs be expanded to allow graduate students of allied health professions to receive loans and grants. Over half of the students of physical therapy are receiving loans and grants to pursue their degrees from the National Direct Student Loan program, the Guaranteed Student Loan program, or the College Work Study program as well as other financial resources that are generally available to all students. However, those pursuing post-baccalaureate degrees find it much more difficult to obtain financial support than those at the undergraduate level. Currently there are 100 accredited physical therapy programs, ten of which are at the post-baccalaureate level. More programs will make the transition to post-baccalaureate in the next few years.

There is a critical need for federal support of post-baccalaureate degrees for physical therapists. While it is true that presently most physical therapists hold baccalaureate degrees, the view of the profession is that the nature of practice today is creating greater demands on the physical therapy educational system. The problems created by those demands are twofold:

- The shortage of physical therapists in the field is exacerbated by the fact that there is a severe shortage of physical therapy faculty.
- Entry level physical therapy practice is increasingly requiring skills ordinarily associated with post-baccalaureate training.

Physical therapy faculty are expected to have post-baccalaureate degrees. Many will need additional training to teach at the post-baccalaureate level.

Unfortunately, the failure of the educational system to offer support for faculty development is directly linked to the inability of the schools to accept more students. The present shortage of physical therapy personnel will, therefore, be extended over many years. As you probably know, the Bureau of Labor Statistics has also predicted a 57 percent increase in employment opportunities for physical therapists by 1990.

Changes in health care practice brought about by advanced technology and a more comprehensive understanding of the human system place increasingly more complex demands on physical therapy practitioners. Likewise, as more is demanded of the practitioner, more is also required of the educational system. To this end, the American Physical Therapy Association has stated that by 1990 entrance into the profession of physical therapy will *require* education and training at the post-baccalaureate level.

In light of the need for graduate trained physical therapists, both to reduce the current faculty shortages and to meet expanded practice requirements, we request that the Committee on Labor and Human Resources legislate faculty training as a top priority within The Special Initiatives Section of the Act (as amended).

The most recent allied health manpower study was published by the Department of Health and Human Services in 1979. Much of the data was gleaned from national organizations such as ours which do not necessarily collect data from the field on personnel needs. Despite the fact that the Bureau of Labor Statistics predicts a 57 percent increase in physical therapy positions by 1990, for example, there is no statistically valid information on the ability of the profession to fill predicted openings or on current "manpower" needs.

An updated comprehensive study of all allied health professions is badly needed to assist Congress in making informed, rational policy decisions on allocation of health professions financial assistance. We therefore request that the Committee instruct the Secretary to include this endeavor as one of the top priorities under Special Initiatives in the near future.

We would also like to see a change in the definition of the term training center for allied health professions (Sec. 759(2)(A)) to include a higher degree (than baccalaureate) in physical therapy. The section would thus read:

> "(A) which provides, or can provide, programs of education leading to a baccalaureate or associate degree (or to the equivalent of either) or to a higher degree in physical therapy, medical technology, optometric technology, dental hygiene, or in any of such other of the allied health professions curricula as are specified by regulation,..."

Moreover, a change in the definition of allied health is in order to reflect the changes in health care provision and the increased expertise and professionalism of allied health personnel. APTA supports the new definition that is proposed by the American Society of Allied Health Professionals.

Thank you for your attention to the foregoing requests. Please let us know if we can be of assistance to the Committee in any way.

American Society for Medical Technology
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March 14, 1984

The Honorable Orrin G. Hatch, Chairman
Senate Committee on Labor and Human Resources
Room 428, Dirksen Senate Office Building
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

As President of the American Society for Medical Technology (ASMT), a professional society comprised of more than 23,000 nonphysician clinical laboratory practitioners nationwide, I write to reiterate ASMT's endorsement of, and to encourage your active support of, the recommendations of the American Society of Allied Health Professions (ASAHP) concerning reauthorization of the Health Professions Education Assistance Act.

The American Society for Medical Technology (ASMT) is a national professional and scientific organization representing over 23,000 nonphysician health professionals who provide the crucial clinical laboratory testing and analytical services on which medical diagnosis and treatment depend. Our members are known variously as clinical laboratory administrators, clinical laboratory managers and supervisors, clinical laboratory scientists, medical technologists, microbiologists, cytotechnologists, clinical chemists, nuclear medicine technologists, hematologists, immunohematologists, medical technicians, histotechnologists, and phlebotomists. They are employed in hospital and independent laboratories, research institutes, industry, blood banks, physicians' offices, and clinics nationwide.

The past three years particularly have riveted the nation's attention on the soaring costs of health services. As you know, a primary consequence of this focus has been long-overdue legislation and regulation effecting crucial changes in the Medicare program's payment policies (e.g., regulations governing Medicare payment for the services of hospital-based physicians, and the enactment of prospective payment). ASMT has been intensively involved in supporting key elements of both the Tax Equity and Fiscal Responsibility Act of 1982 and the Social Security Amendments of 1983, and subsequent federal regulation implementing. or seeking to implement, these cost-curtailment policies.

Because of our commitment to cost-effective, high-quality health services, we have long supported initiatives that seek to enable qualified professional health practitioners to offer their services competitively, without unfair and unnecessary encumbrances. We view the provision of appropriate support for professional allied health education and training as crucial if there is to be qualified competition in health services delivery and if the nation's priority goal of cost-effective, reliable health care is to be realized.

Particularly in the long term, neither policies designed to contain costs at the service-delivery point, nor efforts to contain costs by changing consumer and third-party payor practices, will be fully effective by themselves. We believe that such measures must be complemented by foresightful provisions for educating adequate numbers and kinds of health care professionals who can both provide the health services our citizens need and effectively manage the costs and quality of those services.

As recent changes in the Medicare program's payment practices have made clear, health practitioners must not only be responsible for competent care, but also for the costs associated with providing that care. Nowhere is this more evident than in the nation's clinical laboratories.

While in the past, hospitals often tended to view the clinical laboratory as a profit center able to offset losses sustained in other service centers, today's hospital and clinical laboratory administrators know very well indeed that the clinical laboratory, like every other hospital department, is also a cost center. However, if those administrators are to manage service delivery effectively, they must have sufficient administrative flexibility to do so. Among the crucial components of that administrative flexibility is, and will increasingly be, the latitude to rely more and more on the sophisticated professional competencies of non-physician professionals.

Needless to note, unless the nation's allied health education programs, including educational programs for clinical laboratory professionals, are given the necessary support for (1) developing curricula designed to meet rapidly-changing health services delivery demands, (2) offering education and training programs to sufficient numbers of prospective practitioners, and (3) keeping pace with changes in scientific, business, communications and other technologies and administrative/managerial practices, the necessary flexibility the health services delivery system must possess to meet the needs of a very demanding future will be absent. This is true not only of the clinical laboratory, but also of the entire range of professions encompassed within the allied health disciplines.

For these reasons, the American Society for Medical Technology (ASMT) urges your strongest support for the following recommendations relative to the reauthorization of the Health Professions Educational Assistance Act, as amended by P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981:

- Changing the current federal definition of "allied health professional," to reflect not only the range of functions performed by allied health professionals, but also more accurately to recognize the high standards of professional education and training these key practitioners must characteristically obtain, and the level of professional responsibility they assume in the daily provision of crucial health care;

- Inclusion of a representative from the allied health professions on the National Advisory Council on Health Professions Education. It should go without saying that equal representation of all health professions on the Advisory Council is required to ensure an adequately informed, appropriately balanced health professions education advisory process. Equally significant, such representation is particularly timely in view of the growing recognition of allied health professionals' substantial potential significantly to reduce the cost of first-rate health care;

- Training and educational assistance to individuals from disadvantaged backgrounds for entry into allied health professions, through a separate funding authority. First, the nation must address and strengthen the educational and employment bedrock on which our minorities and disadvantaged depend if we all are to benefit from their fullest human capabilities. The allied health disciplines unquestionably offer promising career opportunities to qualified individuals. Second, it has long been recognized that where practitioners and consumers of health services share a common cultural background, their shared goals of wellness and effective illness prevention are more likely to be met. And third, significantly, allied health professions education programs are more realistically achievable by disadvantaged persons, and can yield more cost-effective career practitioners, than extraordinarily costly physician education programs.

- Eligibility under the Health Education Assistance Loan (HEAL) program and the Health Professions Student Loan (HPSL) program of graduate students in the allied health professions. In our view, the cost of obtaining an appropriate health-related education should not be the only, or perhaps even the primary, consideration in determining loan eligibility criteria. Rather, as recent developments in Medicare cost assessments and payment practices have underscored, it is crucial to link access to health services education to the practitioner's potential to provide highest quality health services cost-effectively.

- Similarly, exceptional financial need scholarships should be made available to graduate students attending schools of allied health. Once again, if this nation is to realize the related goals of cost-effective, high-quality health and economic prosperity, we believe it must be willing to assure equal access to health services delivery education and training for its most promising practitioners, regardless of their financial backgrounds.

- And not least, project grants and contracts must be continued for the allied health professions if, together, we are to meet established national priorities in cost-effective, quality health care. As is made clear in In Search of Excellence, a recent analysis of the management practices of our nation's most successful businesses, there are no gains without the encouragement of new ideas and new techniques. Such, we believe, is the fundamental purpose of the grants and contracts mechanisms we encourage you to support.

I very much appreciate your consideration of our views on this matter. If I can provide you with any additional information, or if I or the American Society for Medical Technology can ever be of any service to you, please be sure to contact Jane Sidney Oliver, Acting Director of the ASMT Washington Office at the address shown on this letterhead.

Sincerely,

H. Elise Galloway

H. Elise Galloway
President

HEG:joe

ASAHP
Vanguard of the
Allied Health Movement

American Society
of Allied Health Professions

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COMMENTS

OF THE

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

CONCERNING

THE

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT

TITLE VII OF THE

PUBLIC HEALTH SERVICE ACT

February 23, 1984

On behalf of the Board of Directors of the Amerian Society of Allied Health Professions, we would like to take this opportunity to address the needs of the allied health professions in relation to the upcoming reauthorization of the Health Professions Educational Assistance Act, Title VII of the Public Health Service Act.

The American Society of Allied Health Professions (ASAHP) is the national nonprofit scientific and professional organization formed to serve the needs of allied health educators, practitioners, professional institutions and organizations, and others interested in improving health care and health-care education. ASAHP has as its ultimate goal the best possible training and utilization of all allied health professionals. As a means to that goal, the Society provides a vital forum in which allied health educators and practitioners--their educational and clinical institutions and their professional associations--can address and act on mutual concerns.

Along with over 1,200 individual members, the Society serves and represents a constituency of 20 professional organizations (whose members total approximately 310,000 professionals in related services), and 120 collegiate schools of Allied Health, containing close to 1,000 allied health educational programs and graduating approximately 36,500 professionals each year. Statistics from a 1979-80 survey show that graduates of the allied health sciences account for as many as 1 out of every 11 graduates from higher education institutions listed by the U.S. Department of Education.

The population which the Society serves is a heterogeneous group of over 3 million professionals engaged in diverse health services, ranging from relatively high-level and increasingly autonomous health care functions (therapists, technologists, administrators) to supportive ones (assistants, aides) including:

- emergency services (e.g., emergency medical technicians, emergency/disaster specialists, physician assistants);
- reception and screening (e.g., medical or dental secretaries, medical office assistants);
- initial screening and evaluation (e.g., physician assistants, dental hygienists, mental health technologists, medical social workers, physical therapists);
- continued assessment as part of treatment (e.g., physical therapists, occupational therapists, respiratory therapists, speech-language pathologists, audiologists, dieticians);

- testing (e.g., medical laboratory personnel, physical therapists, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);

- acute care therapy (e.g., operating room technicians, obstetrical assistants, surgeon's assistants, physical therapists);

- long-term care therapy (e.g., occupational, physical and other therapists; personnel in mental health, social services, counseling, speech-language pathology, audiology, nutrition);

- medical instrumentation (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, ophthalmic dispensers, dental laboratory technicians);

- community health promotion and protection (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers).

As evidenced from 1982 census data, allied health professions make up considerably more than one-half of the nation's total health work force.

GROWTH OF THE ALLIED HEALTH WORKFORCE

The service delivery context for this workforce is currently in an unprecendented state of flux. New service delivery settings and reimbursement policies, demographic changes, and economic pressures could have either positive or negative effects on future growth rates for the professions that comprise this workforce. In addition, there is clear evidence of a seriously shrinking applicant pool.

According to the Bureau of Labor Statistics, allied health careers remain one of the few areas which offer an excellent outlook for employment. A major study by the American Hospital Association, funded by the Bureau of Health Professions, found significant hospital vacancies in many allied health areas.

A 1982 survey of educational program directors conducted by the American Society of Allied Health Professions through its National Center for Allied Health Leadership, revealed that many employers were having difficulty filling job openings. Of the 800 program directors who had "met with two or more employers in (their) area to discuss their needs for graduates with certain knowledge and skills," over half reported that employers were having difficulty filling job openings. Moreover, the job placement record of programs surveyed was extraordinarily good: 59% placed virtually all their graduates in jobs within their professional area, and only 8% reported that fewer than 80% of their graduates found appropriate jobs.

At the same time, the survey found that close to half the department heads reported having a harder time recruiting students than they had in the past, and only 18 percent indicated that recruitment was becoming less difficult. This evidence of a shrinking applicant pool corroborates the results of the 1979-80 ASAHP Collegiate Census conducted under contract #HRA-232-79-0095. It is consistent with findings from single professions. The most probable explanation for the decreasing student pool in allied health is the growth of other career opportunities--for high-aspiring women. Like other relatively low-salaried professions that are predominantly female (e.g., elementary and secondary school teaching), the allied health professions' workforce may be seriously affected by the changing aspirations of women.

For educational programs and federal agencies, the uncertainty over future employer and student demand makes any serious planning effort extremely difficult. Planning, in effect, is occurring in a vacuum. Currently, it appears that an imbalance exists in the supply-demand situation for the professions as a whole--with demand exceeding actual supply and also possibly exceeding the applicant pool. The state of flux in the health service delivery system may create an entirely new scenario in the next few years. Systematic tracking of those factors affecting growth rates of the professions is a number one priority.

CONTRIBUTIONS OF ALLIED HEALTH PROFESSIONALS

Allied health personnel can make a significant difference in national efforts to increase access to health care while holding down costs. The services they provide are relevant to both traditional health care and such relatively new concerns as disease prevention, health promotion, mental and social health, and problems relating to aging, alcoholism, and drug abuse. They contribute large proportions of staff in such "new settings" as rural clinics, health maintenance organizations, and hospices. The allied health professions are well suited to assuming leadership roles in meeting new health needs because they are not as tradition-bound as the older health professions and because, in some cases, their preparation is interdisciplinary, spanning the physical, biological, and social sciences, and they will play an increasingly important role in health care in the next decade and beyond. For example, the significant growth of the aging population, accompanied by an anticipated baby boom, will require increased attention to the needs of the very old and the very young--the services provided by allied health professionals in areas such as rehabilitation, mental health, and school and community health will be most important in meeting these needs.

Among the other trends which indicate a greater future role for allied health services are increased national commitments to meeting the health needs of the nation's medically underserved populations, health promotion and disease prevention, mental health services, increased access to health services, and health care cost containment.

Prospective payment and the increasing competition from alternate health services providers create significant incentives for hospitals to contain costs. In the years ahead, hospitals will find themselves competing more so than ever before with free-standing clinics, emergency care centers, surgical care centers, health maintenance organizations, preferred provider organizations, individual practice associations, and other forms of group practice for consumers' business. In order to survive these competitive conditions, hospitals and other health service providers will have to pare unnecessary costs from their operations.

Allied health personnel offer a significant advantage to those who must deal with these changing market needs--allied health labor is characteristically less costly than physician or other health professionals' labor. In many instances, the services physicians provide in many health care settings do not require a physician to perform them. Consequently, hospitals and other suppliers of health services will have a natural incentive to want to use nonphysicians for physician labor whenever possible. In other instances, health service providers may seek to use allied health personnel as a cost-effective means for enhancing the availability and quality of services offered to consumers. Indeed, the availability of qualified, competent allied health personnel is essential to any national program designed to eliminate needless, wasteful costs while preserving the multiplicity of health care services provided to consumers.

Because of the large number of allied health professions and the relatively small membership of some, the public is generally unaware of the extent to which allied health personnel contribute to patient care and health promotion. Nor, it seems, does the public understand that allied health professions differ considerably in requisite competencies and amounts of education required to perform their services effectively. This lack of public recognition has serious consequences--notably inadequate federal support and peripheral legislative attention, particularly in comparison with medicine, dentistry, and nursing.

THE FEDERAL FUNDING ROLE

Allied health professionals, who comprise close to two-thirds of the health workforce and who play increasingly important roles in meeting the nation's critical health service needs, are essential to the national well-being. Allied health education, therefore, should be viewed as a resource for the community, the state, and the nation. The responsibility of the federal government is to provide the support necessary to ensure that national-level priorities are met.

Federal legislation related to the preparation of allied health professionals began with the Allied Health Professions Personnel Training Act of 1966. The initial impetus for allied health legislation was the critical manpower shortage which existed in the mid-sixties, and the early funding provided under the Act for the development of educational resources contributed significantly to the rapid increase of qualified allied health practitioners. Today, however, funding made available for allied health related purposes through the Health Resources Administration's Bureau of Health Professions is not utilized, nor has it been utilized during any of the past seven years, for the purpose of increasing the supply of allied health manpower. Basic student aid in the allied health professions has not been an object of federal funding support during this period. The limited funds made available during this period have been used to improve access, quality and cost effectiveness in allied health education.

In the past, allied health education has been allocated only a miniscule share of federal funding in comparison with its contribution to the health of the nation. During fiscal year 1984, a total of $198.4 million was appropriated by the federal government for health manpower education; only $800,000, .04 percent, was allocated to allied health education. The extent of this imbalance in funding imperatives is even more dramatic in light of the fact that individuals involved in allied health professions compose a significant portion of the nation's total health manpower, and that the appropriate use of allied health practitioners can produce substantial health care cost economies and extend the reach of available health care services to the traditionally unserved and underserved areas of this country.

THE FEDERAL ROLE IN ALLIED HEALTH EDUCATION

What are the priorities to which significantly increased federal emphasis on Allied Health should be put? Here are some suggestions:

1. CHANGE THE DEFINITION OF ALLIED HEALTH PROFESSIONAL.

Recognition has been hampered by the inadequacy of the federal government's definition of "allied health personnel" as individuals with training and responsibilities for (a) supporting, complementing and supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (b) assisting environmental health control and preventive medicine activities.

This definition is vague and confusing and fails to encompass the range of functions performed by allied health professionals.

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2. There shall be three full-time students enrolled in health professions schools or allied health professions educational programs and ... (remainder of Section 701).

National Advisory Council on Education for Health Professions

Proposed amendment to the Public Health Service Act as amended by Public Law 97-35, The Omnibus Budget Reconciliation Act of 1981.

Section 701 is amended to read as follows:

(a) There is established in the Public Health Service a National Advisory Council on Health Professions Education (hereafter in this section referred to as the "Council"), consisting of the Secretary (or his delegate), who shall be Chairman of the Council, and twenty members appointed by the Secretary (without regard to the provisions of Title 5 relating to appointments in the competitive service) from persons who because of their education, experience, or training are particularly qualified to advise the Secretary with respect to the programs of assistance authorized by parts B, C, D, E, F, and G of this subchapter. Of the appointed members of the Council (1) twelve shall be representatives of health professions schools and allied health professions educational programs, including at least one representative each of schools of veterinary medicine, optometry, pharmacy, and podiatry, at least one representative of an allied health professions educational program, and at least one representative of schools of public health and graduate programs in health administration; (2) three shall be full-time students enrolled in health professions schools or allied health professions and educational programs; and (3) five shall be members of the general public.

3. ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS SHOULD BE TARGETED TO ALLIED HEALTH SCHOOLS AND ASSOCIATIONS UNDER A SEPARATE AUTHORITY.

Increasing the representation of minorities in the allied health professions is important to meet the health needs of diverse cultures and ethnic groups. Moreover, Allied health professions represent an excellent avenue for social mobility for disadvantaged minorities, because they are among the limited number of occupations in the economy for which the employment outlook is almost uniformly favorable. Minorities are substantially under-represented in educational programs for the relatively high-level Allied Health professional (i.e., baccalaureate and advanced degree programs).

A 1980 national census of collegiate allied health programs, conducted by the American Society of Allied Health Professions, showed that out of the 131,035 students enrolled, black students accounted for only 8 percent of the students enrolled in bachelor and graduate programs and 9 percent of those in associate degree programs. Also only 7 percent of the 1978-79 graduates were black.

The study also found that Hispanics accounted for just 3 percent of enrollments and graduates. American Indians, Asians and other nonwhite groups together accounted for just 3 percent of enrolled students and 1 percent graduates.

We believe that allied health can provide special training opportunities for minority group members which the costlier longer-term health professions training programs can not provide. Therefore, an emphasis on these special entry-to-the-profession opportunities should be encouraged.

Existent legislation favors support of academic entities which link themselves with medical schools or other health professional schools. This is counterproductive for many reasons most important among which are: (1) the allied health professions should be represented as a free standing "self-important" group as they provide substantial opportunities for employment and social mobility, and (2) the majority of disadvantaged individuals who pursue careers in the allied health professions do not enter programs which are affiliated with medical schools. Most of these individuals enter programs in 2-year and 4-year college settings. The present system sharply discriminates against 2-year allied health education programs.

Therefore, we recommend that a separate authority be established for associations and schools of allied health to assist disadvantaged individuals.

Educational Assistance to Disadvantaged Individuals in Allied Health Training

Section 798 is amended to read as follows:

(a)(1) For the purpose of assisting individuals who, due to socioeconomic factors, are financially or otherwise disadvantaged (including individuals who are veterans of the Armed Forces with military training or experience in the health field) to undertake education to enter the allied health professions, the Secretary shall make grants to and enter into contracts with schools of allied health, State and local educational agencies, and other public or private nonprofit entities to assist in meeting the costs described in paragraph (2).

(2) A grant or contract under paragraph (1) may be used by the school, agency, or entity to meet the costs of --

(A) identifying, recruiting, selecting, and retaining such individuals,

(B) facilitating the entry to such individuals into schools of allied health professions,

(C) providing counseling or other services and studies designed to assist such individuals to complete successfully their education in an allied health profession,

(D) providing, for a period prior to the entry of such individuals into the professional program of education at an allied health professions school, preliminary education designed to assist them to complete successfully such allied health professional education.

(b)(1) No grant may be made or contract entered into under subsection (a) unless an application therefor has been submitted to, and approved by, the secreatry. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) The amount of any grant under subsection (a) shall be determined by the Secretary.

(c) For payments under grants and contracts under subsection (a) there are authorized to be appropriated $3,000,000 for fiscal year ending September 30, 1985, $3,000,000 for fiscal year ending September 30, 1986, $3,000,000 for fiscal year ending September 30, 1987, $3,000,000 for fiscal year ending September 30, 1988, and $3,000,000 for fiscal year ending September 30, 1989.

4. ELIGIBILITY UNDER THE HEALTH EDUCATION ASSISTANCE LOAN (HEAL) AND HEALTH PROFESSIONS STUDENT LOAN (HPSL) PROGRAMS SHOULD BE EXTENDED TO INCLUDE GRADUATE STUDENTS OF ALLIED HEALTH.

Federal reductions in all student support programs, especially for graduate students, have coincided with dramatic increases in tuition costs. Between 1969 and 1981, graduate tuition and fees more than tripled, with average annual increases of about ten percent. During the same period, private institutions raised their tuition and fee levels nearly five-fold, with average annual increases of approximately 12 percent.

While a number of traditional student aid programs -- College Work Study (CWS), Guaranteed Student Loans (GSL) and National Direct Student Loans (NDSL) -- have helped students meet the cost of graduate study, there are still significant numbers of graduate students who have no resource to fall back on to finance their education (either through lack of qualification for these programs, or because of overexpended loan programs). Occupational therapy program directors alone estimate that 90 percent of students in private universities and 60-75 percent of students in lower tuition programs need loan assistance. An alternative to these traditional sources of aid would be to include students of allied health under the Health Education Assistance Loan (HEAL) and Health Professions Student Loan (HPSL) programs.

To date, eligibility for the HPSL program has been open exclusively to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry and pharmacy (MODVOPPs). Similarly, the HEAL program is available to the MODVOPPs, however, with the advent of the Omnibus Budget Reconciliation Act of 1981, HEAL was expanded to include students of chiropractic medicine and graduate clinical psychology. The 1981 amendments also enabled graduate students of schools of public health and health administration to apply for HPSL benefits.

Changes in health care practice brought about by advanced technology, a more comprehensive understanding of the human system, and cost containment efforts place increasingly more complex demands on therapists, technologists and certain related disciplines. As more is demanded of the practitioner, more is also required of the educational system. To this end, more of the allied health professions will require education and training at the post-baccalaureate level.

According to a survey of allied health collegiate programs conducted by the American Society of Allied Health Professions in 1980, 337 schools offered an aggregate of 1,471 graduate and doctoral level programs. Graduate programs were found among the following occupations: speech-language pathologists/audiologist, biomedical engineer, corrective therapist, dietitian/nutritionist, environmental health engineer, environmentalist, exercise physiologist, health educator (community/school), health services administrator, occupational therapist, physical therapist, recreation therapist, and rehabilitation counselor.

There are approximately 19,305 students in graduate and doctoral programs in allied health schools. The average tuition is $5,000 per year. If these loans and grants became available, it is probable that for the academic year 1985-86, 25 percent of the students would be interested in HPSL loans of $2,200 per year. Perhaps 5 percent of the student population would desire a HEAL loan. Requested appropriation for graduate students in allied health under the HEAL and HPSL programs are $7.3 million and $10.6 million respectively per fiscal year.

Graduate education in the allied health professions should be an integral component in the continuum of health professions education. While graduate education takes different forms and serves different purposes in the health professions, it is primarily directed toward preparation for practice and may be required for licensure. In addition, it is intimately connected to the preparation of faculty, researchers, and administrators and the development of new knowledge. To this end, the primary goal is to develop experts with the appropriate knowledge, skills and attitudes in a special area.

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Stability in graduate education is seriously undermined when federal support is unreliable or fluctuates. Unless adequate student aid is available, the nation will not be able to attract the talented young people it needs into graduate programs of allied health. Therefore, we recommend that eligibility under the HEAL and HPSL programs be extended to include graduate students of allied health.

STUDENT ASSISTANCE

Proposed amendment to the Public Health Service Act as amended by Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981.

Limitations on Individual Federally Insured Loans and on Federal Loan Insurance

Section 729 is amended to read as follows:

(a) The total of the loans made to a student in any academic year or its equivalent (as determined by the Secretary which may be covered by Federal loan insurance under this support may not exceed $20,000 in the case of a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry; $12,500 in the case of a student enrolled in a school of pharmacy, public health, or chiropractic, or a graduate program in health administration or clinical psychology; or $5,000 in the case of a student enrolled in a graduate program in allied health. The aggregate insured unpaid principal amount for all such insured loans made to any borrower shall not at any time exceed $80,000 in the case of a borrower who is or was a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry; $50,000 in the case of a borrower who is or was a student enrolled in a school of pharmacy, public health, or chiropractic, or a graduate program in health administration or clinical psychology; and $20,000 in the case of a borrower who is or was a student enrolled in a graduate program in allied health. The annual insurable limit per student shall not be exceeded by a line of credit under which actual payments by the lender to the borrower will not be made in any year in excess of the annual limit.

Definitions: Student Assistance

Section 737 is amended to read as follows:

"(1) The term 'eligible institution' means, with respect to a fiscal year, a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health or chiropractic, or a graduate program in health administration, clinical psychology or allied health."

"(4) The term 'graduate program in allied health' means a graduate program in a public or nonprofit private institution in a State which provides training leading to a post-baccalaureate credential in allied health or an allied health discipline, and which is accredited in the manner described in Section 701(10)."

Loan Agreements for Establishment of Student Loan Funds

Section 742 is amended to read as follows:

(a) The Secretary is authorized to enter into an agreement for the establishment and operation of a student loan fund in accordance with this subpart with any public or other nonprofit school of medicine, osteopathy, dentistry, pharmacy, podiatry, optemetry, veterinary medicine or allied health located in a State and is accredited as provided in Section 293a(b)(1)(B) of this title.

Terms and Conditions

(b) Each agreement entered into under this section shall--

(1) provide for establishment of a student loan funded by the school;

(2) provide for deposit in the fund of (A) the Federal capital contributions to the fund (B) an amount equal to not less than one-ninth of such Federal capital contributions, contributed by such institution, (C) collections of principal and interest on loans made from the fund, (D) collections pursuant to Section 294(a)(j) of this title, and (E) any other earnings of the fund;

(3) provide that the fund shall be used only for loans to students of the school in accordance with the agreement and for costs of collection of such loans and interest thereon;

(4) provide that loans may be made from such fund only to students pursuing a full-time course of study at the school leading to a degree of doctor or medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equivalent degree doctor of podiatry or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, or a post-baccalaureate credential in allied health;

(5) provide that the school shall advise, in writing, each applicant for a loan from the student loan fund of the provisions of Section 294(n) of this title under which outstanding loans from student loan fund may be paid (in whole or in part) by the Secretary; and

(6) contain such other provisions as are necessary to protect the financial interests of the United States.

Loan Provisions

School Year Limitation

(a) Loans from a student loan fund (established under an agreement with a school under Section 294m of this title) may not exceed for any student for each school year (or its equivalent) the sum of --

(1) the cost of tuition for such year at such school, and

(2) $2,500

School Determination of Terms and Conditions; Needy Students Eligible

(b) Any such loans shall be made on such terms and conditions as the school may determine, but may be made only to a student in need of the amount thereof to pursue a full-time course of study at the school leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equivalent degree, doctor of podiatry or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree or a post-baccalaureate credential in allied health.

Repayment in Periodic Installments; Acceleration; Commencement and Duration of Period; Exclusions from Period

(c) Such loans shall be repayable in equal or graduated periodic installments (with the right of the borrower to accelerate repayment) over the ten year period which begins one year after the student ceases to pursue a full time course of study at a school of medicine, osteopathy, dentistry, pharmacy, podiatry, optometry, veterinary medicine or allied health, excluding from such ten year period all periods (up to three years) of (1) active duty performed by the borrower as a member of a uniformed service, or (2) service as a volunteer under the Peace Corps Act; and periods of advanced professional training including internships and residencies).

Cancellation of Liability for Repayment

(d) The liability to repay the unpaid balance of such a loan and accrued interest thereon shall be canceled upon the death of the borrower, or if the Secretary determines that he has become permanently and totally disabled.

Interest

(e) Such loans shall bear interest, on the unpaid balance of the loan, computed only for periods for which the loan is repayable, at the rate of 9 percent per year.

Payment of Principal and Interest for Practice in Physician, etc., Shortage Areas; Limitation; Liability for Reimbursement; Election of Loan Cancellation under Amended or Original Provisions

(f)(1) In the case of any individual --

> (A) who has received a degree of doctor of medicine, doctor of osteopathy, doctor of dentistry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, doctor of optometry or an equivalent degree, bachelor of science in pharmacy or an equivalent degree doctor of podiatry or an equivalent degree, or a post-baccalaureate credential in allied health.
>
> (B) who (i) obtained one or more loans from a loan fund established under this subpart, or (ii) obtained, under a written loan agreement entered into before October 12, 1976, any other educational loan for his costs at a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or allied health; and ....

5. EXCEPTIONAL FINANCIAL NEED SCHOLARSHIPS SCHOULD BE MADE AVAILABLE TO GRADUATE STUDENTS ATTENDING SCHOOLS OF ALLIED HEALTH.

Students in health professions education are bearing an increasing financial burden because of the increase in tuition and fees at many schools and the decrease in student financial aid. There is a decrease in both external funding of financial aid and of scholarships and loan funds controlled by the schools themselves. Concern has been expressed about how the increase in educational costs to students will affect the composition of applicant pools and of classes, as well as how it will affect the choice of profession, specialty, and practice location.

Qualified students should have an equal chance of entering the health professions, regardless of their financial background. Further, the health professions should be representative of all races and socioeconomic groups in the U.S.; there is some evidence that such wide representation will improve the overall quality of health care. Some studies have indicated that students tend to work or practice in the geographic area and the urban or rural settings where they grow up. Thus, careful student recruiting may serve as a means of providing health care to isolated or underserved areas.

Qualified students may make adjustments in their career selection based on their ability to pay tuition and to meet living costs, particularly if they are unwilling to incur substantial educational debt. It is entirely possible that many qualified people do not apply to health professions education program for financial reasons.

To date, schools of medicine, osteopathy, dentistry, opteometry, pharmacy, poidatry, and veterinary medicine have been awarded federal grants so that they may extend scholarships to to first-year graduate students of exceptional need. There are a substantial number of graduate students in allied health programs as well (over 19,000 in 1980), many of which could profit from this program. Therefore, we strongly recommend that the scholarship program for first-year students of exceptional financial need be extended to include schools of allied health.

Scholarships for First Year Students of Exceptional Financial Need

Proposed amendment to the Public Health Service Act is amended by Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981.

Section 758 is amended to read as follows:

(a) The Secretary shall made grants to a public nonprofit school of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine or allied health which is accredited as provided in Section 293(a)(b)(1)(B) of this title for scholarships to be awarded by the school of full-time students thereof who are of exceptional financial need and who are in their first-year of study at such school.

6. PROJECT GRANTS AND CONTRACTS SHOULD BE CONTINUED FOR THE ALLIED HEALTH PROFESSIONS TO MEET THE NEEDS OF ESTABLISHED NATIONAL PRIORITIES AND TO HELP BUILD THE CAPABILITY FOR LEADERSHIP AND INNOVATION

The case for continued federal activity on behalf of allied health personnel is predicated on the (1) potential health care cost savings through more effective personnel utilization, (2) lack of resources for research, development and demonstration of improvements in training in personnel, and (3) value to states and to the private sector of a federal focal point for allied health personnel activity.

Modest but sharply focused federal initiatives are needed to ensure effective use of allied health personnel. As is the case with the entire health care system, there is an important federal role crucial to the issues of quality assurance, cost containment, geographic and specialty distribution, minority representation, care for the aged, terminally ill and bilingual groups and equal access to health care. Because of the dynamic nature of health care delivery and rapidly changing practice needs, allied health education must not remain static. It is essential to develop the capability for leadership and innovation. Support is needed for activities on which future improvements in allied health education and services are dependent.

We are therefore requesting the following legislative action:

1. Section 795 be repealed.
2. Section 796 be amended at attached hereto.
3. Section 797 be allowed to expire.

Project Grants and Contracts

Proposed amendement to the Public Health Service Act as amended by Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981.

Section 796 is amended to read as follows:

(a) The Secretary in accordance with established national priorities, shall make grants to and enter into contracts with eligible entities to assist them in meeting the costs of planning, developing, demonstrating, operating, and evaluating projects related to:

(1) Methods for increasing the efficiency and reducing the costs of health care delivery through more effective use of allied health personnel.

(2) Continuing education (competency updating, faculty development and advanced training) for allied health professionals.

(3) Appropriate retraining opportunities for allied health personnel who, after periods of professional inactivity, desire again actively to engage in the practice or teaching of their allied health profession.

(4) Improving the distribution and availability by geographic area or by specialty group of adequately trained allied health personnel needed to meet the health needs of the Nation, including the need to increase the availability of primary care services, services to the elderly, services to bilingual groups and the need to promote preventive health care.

(5) Providing training and education to upgrade the skills of allied health assistants and other

subprofessional allied health personnel, as designated by the Secretary, employed in acute, chronic, and long-term care institutions.

(6) Educational programs which permit individuals to become proficient in a related specialty.

(7) Ways to meet changing needs in health care delivery with out creating new allied health occupations or specialities.

Contracts may be entered into under this subsection without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(b) "The term 'Allied Health Professional' means an individual trained at the associate, baccalaureate, master's, or doctoral degree level in health care related science, with responsibility for the delivery of health care or health care related services (including services related to the identification, evaluation and prevention of diseases and disorders, dietary and nutrition services, health promotion, rehabilitation, and health systems management), but who are not graduates of schools of medicine, optometry, podiatry, pharmacy, or nursing."

(c) The term 'school of allied health' means a regionally accredited public or nonprofit private two-year college, senior college, or university --

(1) which provides, or can provide professionally accredited programs of education in a discipline of allied health leading to an associate or baccalaureate degree or to a more advanced level;

(2) which provides training for not less than a total of twenty persons in the allied health curricula; and

(3) which includes or is affiliated with a teaching hospital.

(d) The Secretary may, with the advice of the National Advisory Council on Health Professions Education, provide assistance to the heads of other departments and agencies of the Government to encourage and assist in the utilization of medical facilities under their jurisdiction for allied health training programs.

(e) No grant or contract may be made under this section unless an application thereof has been submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Health Professions Education. Such an application shall provide for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this section.

(f) For payments under grants and contracts under this section there are authorized to be appropriated $10,000,000 for fiscal year ending September 30, 1985, $10,000,000 for fiscal year ending September 30 ,1986, $10,000,000 for fiscal year ending September 30, 1987, $10,000,000 for the fiscal year ending September 30, 1988, and $10,000,000 for the fiscal year ending September 30, 1989.

CONCLUSIONS

If allied health services are essential to the well-being of the nation, then allied health education is equally essential. Allied health services depend on allied health education. The informally and haphazardly prepared health practitioner might have suited the level of sophistication of health care delivery at the turn of the century; today, the knowledge and skills required to perform health services are much more advanced. Formal education programs for most allied health professions are the only means of ensuring that a sufficient number of personnel will be adequately prepared. In addition, eligibility under all student aid and scholarship programs is essential to enable students to access formal education programs. Although, some individuals may be able to acquire the necessary knowledge and skills by other means, most will require formal post-secondary preparation ranging from short-term training to graduate study.

Moreover, the continued improvement of allied health services -- in terms of quality, cost effectiveness, access, and continuity -- depends on allied health education. Without advanced programs and formal leadership development, it unlikely that the necessary research and development activities will be conducted. These research and development activities can lead to improvement in services directly and also indirectly by improving educational processes which in turn lead to better prepared practitioners. The future of health services and health service delivery depends on financial support for allied health education and a renewed commitment on the part of the federal government to provide its fair share of that support.

If you have any questions, or need further clarification, please feel free to contact us.

Sincerely,

Polly A. Fitz — Carolyn A. Del Polito

Polly A. Fitz, M.A.
President

Carolyn Del Polito, Ph.D.
Executive Director

ASAHP
U840223

ENDORSING ORGANIZATIONS

American Art Therapy Association
American Dental Hygienists' Association
American Dietetic Association
American Medical Association
American Medical Record Association
American Medical Technologists
American Occupational Therapy Association
American Physical Therapy Association
American Society Therapy Association
American Association of Bioanalysts
American Society for Medical Technology
American Speech-Language-Hearing Association

PAF:CDP/tah

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ASAHP
Vanguard of the
Allied Health Movement

**American Society
of Allied Health Professions**

1101 Connecticut Avenue, N.W., Suite 700, Washington, D.C. 20036 202/857-1150

TESTIMONY

OF THE

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

ON THE

HEALTH PROFESSIONS ACT
TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

SUBMITTED TO THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

March 15, 1984

Dear Mr. Chairman:

My name is Polly Fitz. I am President of the American Society of Allied Health Professions and Dean of the School of Allied Health Professions at the University of Connecticut. On behalf of the Board of Directors of the American Society of Allied Health Professions, I would like to take this opportunity to submit our comments for the record on the needs of the allied health professions in relation to the reauthorization of the Health Professions Act, Title VII of the Public Health Service Act.

The American Society of Allied Health Professions (ASAHP) is the national nonprofit scientific and professional organization formed to serve the needs of allied health educators, practitioners, professional institutions and organizations, and others interested in improving health care and health-care education. ASAHP has as its ultimate goal the best possible training and utilization of all allied health professionals. As a means to that goal, the Society provides a vital forum in which allied health educators and practitioners--their educational and clinical institutions and their professional associations--can address and act on mutual concerns.

Along with over 1,200 individual members, the Society serves and represents a constituency of 20 professional organizations (whose members total approximately 310,000 professionals in related services), and 120 collegiate schools of Allied Health, containing close to 1,000 allied health educational programs and graduating approximately 36,500 professionals each year. Statistics from a 1979-80 survey show that graduates of the allied health sciences account for as many as 1 out of every 11 graduates from higher education institutions listed by the U.S. Department of Education.

The population which the Society serves is a heterogeneous group of over 3 million professionals engaged in diverse health services, ranging from relatively high-level and increasingly autonomous health care functions (therapists, technologists, administrators) to supportive ones (assistants, aides) including:

- emergency services (e.g., emergency medical technicians, emergency/disaster specialists, physician assistants);

- reception and screening (e.g., medical or dental secretaries, medical office assistants);

- initial screening and evaluation (e.g., physician assistants, dental hygienists, mental health technologists, medical social workers, physical therapists);

- continued assessment as part of treatment (e.g., physical therapists, occupational therapists, respiratory therapists, speech-language pathologists, audiologists, dieticians);

- testing (e.g., medical laboratory personnel, physical therapiSTS, rAdiologic technologists, ultrasound Technical specialists, nuclear medicine personnel, cardiology equipment personnel);

- acute care therapy (e.g., operating room technicians, obstetrical assistants, surgeon's assistants, physical therapists);

- long-term care therapy (e.g., occupational, physical and other therapists; personnel in mental health, social services, counseling, speech-language pathology, audiology, nutrition);

- medical instrumentation (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, ophthalmic dispensers, dental laboratory technicians);

- community health promotion and protection (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers).

As evidenced from 1982 census data, allied health professions make up considerably more than one-half of the nation's total health work force.

GROWTH OF THE ALLIED HEALTH WORKFORCE

The service delivery context for this workforce is currently in an unprecendented state of flux. New service delivery settings and reimbursement policies, demographic changes, and economic pressure could have either positive or negative effects on future growth rates for the professions that comprise this workforce. In addition, there is clear evidence of a seriously shrinking applicant pool.

According to the Bureau of Labor Statistics, allied health careers remain one of the few areas which offer an excellent outlook for employment. A major study by the American Hospital Association, funded by the Bureau of Health Professions, found significant hospital vacancies in many allied health areas.

A 1982 survey of educational program directors conducted by the American Society of Allied Health Professions through its National Center for Allied Health Leadership, revealed that many employers were having difficulty filling job openings. Of the 800 program directors who had "met with two or more employers in (their) area to discuss their needs for graduates with certain knowledge and skills," over half reported that employers were having difficulty filling job openings. Moreover, the job placement record of programs surveyed was extraordinarily good: 59% placed virtually all their graduates in jobs within their professional area, and only 8% reported that fewer than 80% of their graduates found appropriate jobs.

At the same time, the survey found that close to half the department heads reported having a harder time recruiting students than they had in the past, and only 18 percent indicated that recruitment was becoming less difficult. This evidence of a shrinking applicant pool corroborates the results of the 1979-80 ASAHP Collegiate Census conducted under contract #HRA-232-79-0095. It is consistent with findings from single professions. The most probable explanation for the decreasing student pool in allied health is the growth of other career opportunities--for high-aspiring women. Like other relatively low-salaried professions that are predominantly female (e.g., elementary and secondary school teaching), the allied health professions' workforce may be seriously affected by the changing aspirations of women.

For educational programs and federal agencies, the uncertainty over future employer and student demand makes any serious planning effort extremely difficult. Planning, in effect, is occurring in a vacuum. Currently, it appears that an imbalance exists in the supply-demand situation for the professions as a whole--with demand exceeding actual supply and also possibly exceeding the applicant pool. The state of flux in the health service delivery system may create an entirely new scenario in the next few years. Systematic tracking of those factors affecting growth rates of the professions is a number one priority.

FEDERAL FUNDING ROLE

To date, federal initiatives on behalf of the allied health professions have been scarce. It is alarming that such an important segment of the nation's health care workforce virtually has been ignored by Congress. The Omnibus Budget Reconciliation Act of 1981 included sparce appropriations for those sections which included allied health. Authorities for Sections 795, 796, 797 and 798 were not extended beyond FY80. Those sections which survived, 787 and 788, were only appropriated approximately $1 million and $.08 million in both FY83 and FY84 out of a total health professions appropriations of $189.5 million and $198.4 million respectively (.04 percent).

The case for continued federal support is also predicated on (1) the potential cost-savings involved in the utilization of allied health personnel; (2) the need to provide linkages for allied health personnel with the newly implemented Prospective Payment System (PPS); (3) the need to ensure that financially, geographically and otherwise disadvantaged individuals have the opportunity to enter the health professions; (4) the need to ensure access to higher education; and (5) the need to align federal funding with continuing national priorities.

Allied health personnel offer a cost-effective alternative to those who must deal with changing market needs: allied health labor is characteristically less costly than physician labor. In many instances, allied health professionals can provide the same services that physicians perform. Consequently, hospitals and other suppliers of health services have a natural incentive to want to use nonphysician labor whenever possible. The availability of qualified, competent allied health personnel is essential to any national program designed to contain costs while perserving the multiplicity of health care services provided to consumers.

The federal role in providing initiatives to link allied health personnel with prospective payment is crucial. The importance of allied health personnel in the success of this new system cannot be overstressed. For example, the Prospective Payment System (PPS) is based on eventual implementation of a national Diagnostic Related Group (DRG) rate of reimbursement. The success of a hospital's DRG operating system depends on the uniformity and accuracy of that institution's medical records, an area under the auspices of the medical record administrator and associated allied health personnel. Thus, these particular allied health personnel have taken on new and enlarged responsibilities. Also, the PPS incentive to move patients from hospitals to less costly settings is stimulating a demand for rehabilitation specialists, such as physical therapists and occupational therapists, as well as laboratory and radiologic X-ray technicians in these alternative care sites. Thus, as hospitals are faced with the need to cut costs, allied health personnel may be an answer to the cost/quality problem.

Federal initiatives also are needed to ensure that financially, geographically, and otherwise disadvantaged individuals have opportunities to become allied health practitioners. These initiatives should be separated, like nursing, from their previous coupling with medicine, dentistry, podiatry, and other health professions. Existing legislation favors support of academic entities which are linked with medical schools or other health professional schools. This is counterproductive. Two important reasons are: (1) the allied health professions should be rerpesented as a free standing "self-important" group as they provide substantial opportunities for employment and social mobility, and (2) the majority of disadvantaged individuals who pursue careers in the allied health professions do not enter programs which are affiliated with medical schools. Most of these individuals enter programs in 2-year and 4-year college settings. The present system sharply discriminates against 2-year allied health education programs.

Federal initiatives in the area of student aid also are needed, particularly for graduate students in allied health. Graduate education has taken on an increased significance in the allied health professions. Over 19,000 students were enrolled in graduate or doctoral level allied health programs in 1979-80. It is estimated that in the future, more occupations will require graduate degrees for entry-level professional positions. However, current federal reductions in all student support programs and dramatic increases in tuition costs may prove to decrease the number of allied health professionals pursuing a post-baccalaureate degree. Because of the dynamic nature of health care delivery and rapidly changing practice needs, allied health education must not remain static. It is essential to develop the capability for leadership and innovation. Support is needed for activities which will shape future improvements in allied health education and services.

Modest, but sharply focused federal initiatives, are needed to ensure effective use of allied health personnel in addressing national priorities. A crucial role of the Federal government will be to ensure that attention is given to the issues of quality assurance, cost containment, geographic and specialty distribution, minority representation, and equal access to health care for persons who are disabled, aged, terminally ill, and bilingual.

- PROPOSED LEGISLATIVE ACTION

The American Society of Allied Health Professions recommends the following legislative action: (1) reactivate those sections which were rendered inoperative; (2) install new federal initiatives; (3) align these authorities better with contemporary federal priorities; and (4) authorize modest appropriations for FY85-89:

1. CHANGE THE DEFINITION OF ALLIED HEALTH PROFESSIONAL.

Recognition has been hampered by the inadequacy of the federal government's definition of "allied health personnel" as individuals with training and responsibilities for (a) supporting, complementing and supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (b) assisting environmental health control and preventive medicine activities.

This definition is vague and confusing and fails to encompass the range of functions performed by allied health professionals. The image of the allied health professional as one who simply helps the physician may have had some validity many years ago when Allied Health professions were known as allied medical or paramedical occupations. Today, allied health professionals serve many functions--some have little or no contact with physicians, others play roles that are better termed collaborative than supportive, and still others have spawned new occupations.

For federal funding purposes, the allied health concept can be used, as it is currently, to encompass those professions which are not covered by separate medical and nursing legislative authorities. But the term "Allied Health" should become more broadly accepted as a concept connoting a horizontal alliance, rather than a vertical or hierarchical linkage. This alliance should begin with education and extend to health care delivery, and it should include as many professions as possible. The present definition fails utterly in this respect.

Therefore, we recommend that the current definition be repealed and the following definition be inserted in lieu thereof:

> "The term 'Allied Health Professional' means an individual trained at the associate, baccalaureate, master's, or doctoral degree level in health care related science, with responsibility for the delivery of health care or health care related services (including services related to the identification, evaluation and prevention of diseases and disorders, dietary and nutrition services, health promotion, rehabilitation, and health systems management), but who are not graduates of schools of medicine, optometry, podiatry, pharmacy, or nursing."

2. THE PUBLIC HEALTH SERVICE, NATIONAL ADVISORY COUNCIL ON HEALTH PROFESSIONS EDUCATION SHOULD INCLUDE A REPRESENTATIVE OF AN ALLIED HEALTH PROFESSIONS EDUCATIONAL PROGRAM.

To provide for equal representation on the National Advisory Council on Health Professions Education across the health professions, we recommend that members of the Council be appointed as follows:

1. Twelve shall be representatives of health professions schools and allied health professions educational programs, including at least one representative each of schools of veterinary medicine, optometry, pharmacy, and podiatry, at least one representative of an allied health professions educational program, and at least one representative of schools of public health and graduate programs in health administration; and

2. There shall be three full-time students enrolled in health professions schools or allied health professions educational programs and ... (remainder of Section 701).

National Advisory Council on Education for Health Professions

Proposed amendment to the Public Health Service Act as amended by Public Law 97-35, The Omnibus Budget Reconciliation Act of 1981.

Section 701 is amended to read as follows:

(a) There is established in the Public Health Service a National Advisory Council on Health Professions Education (hereafter in this section referred to as the "Council"), consisting of the Secretary (or his delegate), who shall be Chairman of the Council, and twenty members appointed by the Secretary (without regard to the provisions of Title 5 relating to appointments in the competitive service) from persons who because of their education, experience, or training are particularly qualified to advise the Secretary with respect to the programs of assistance authorized by parts B, C, D, E, F, and G of this subchapter. Of the appointed members of the Council (1) twelve shall be representatives of health professions schools and allied health professions educational programs, including at least one representative each of schools of veterinary medicine, optometry, pharmacy, and podiatry, at least one representative of an allied health professions educational program, and at least one representative of schools of public health and graduate programs in health administration; (2) three shall be full-time students enrolled in health professions schools or allied health professions and educational programs; and (3) five shall be members of the general public.

3. ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS SHOULD BE TARGETED TO ALLIED HEALTH SCHOOLS AND ASSOCIATIONS UNDER A SEPARATE AUTHORITY.

Increasing the representation of minorities in the allied health professions is important to meet the health needs of diverse cultures and ethnic groups. Moreover, Allied health professions represent an excellent avenue for social mobility for disadvantaged minorities, because they are among the limited number of occupations in the economy for which the employment outlook is almost uniformly favorable. Minorities are substantially under-represented in educational programs for the relatively high-level Allied Health professional (i.e., baccalaureate and advanced degree programs).

A 1980 national census of collegiate allied health programs, conducted by the American Society of Allied Health Professions, showed that out of the 131,035 students enrolled, black students accounted for only 8 percent of the students enrolled in bachelor and graduate programs and 9 percent of those in associate degree programs. Also only 7 percent of the 1978-79 graduates were black.

The study also found that Hispanics accounted for just 3 percent of enrollments and graduates. American Indians, Asians and other nonwhite groups together accounted for just 3 percent of enrolled students and 1 percent graduates.

We believe that allied health can provide special training opportunities for minority group members which the costlier longer-term health professions training programs can not provide. Therefore, an emphasis on these special entry-to-the-profession opportunities should be encouraged.

Existent legislation favors support of academic entities which link themselves with medical schools or other health professional schools. This is counterproductive for many reasons most important among which are: (1) the allied health professions should be represented as a free standing "self-important" group as they provide substantial opportunities for employment and social mobility, and (2) the majority of disadvantaged individuals who pursue careers in the allied health professions do not enter programs which are affiliated with medical schools. Most of these individuals enter programs in 2-year and 4-year college settings. The present system sharply discriminates against 2-year allied health education programs.

Therefore, we recommend that a separate authority be established for associations and schools of allied health to assist disadvantaged individuals.

Educational Assistance to Disadvantaged Individuals in Allied Health Training

Section 798 is amended to read as follows:

(a)(1) For the purpose of assisting individuals who, due to socioeconomic factors, are financially or otherwise disadvantaged (including individuals who are veterans of the Armed Forces with military training or experience in the health field) to undertake education to enter the allied health professions, the Secretary shall make grants to and enter into contracts with schools of allied health, State and local educational agencies, and other public or private nonprofit entities to assist in meeting the costs described in paragraph (2).

(2) A grant or contract under paragraph (1) may be used by the school, agency, or entity to meet the costs of --

(A) identifying, recruiting, selecting, and retaining such individuals,

(B) facilitating the entry to such individuals into schools of allied health professions,

(C) providing counseling or other services and studies designed to assist such individuals to complete successfully their education in an allied health profession,

(D) providing, for a period prior to the entry of such individuals into the professional program of education at an allied health professions school, preliminary education designed to assist them to complete successfully such allied health professional education.

(b)(1) No grant may be made or contract entered into under subsection (a) unless an application therefor has been submitted to, and approved by, the secreatry. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) The amount of any grant under subsection (a) shall be determined by the Secretary.

(c) For payments under grants and contracts under subsection (a) there are authorized to be appropriated $3,000,000 for fiscal year ending September 30, 1985, $3,000,000 for fiscal year ending September 30, 1986, $3,000,000 for fiscal year ending September 30, 1987, $3,000,000 for fiscal year ending September 30, 1988, and $3,000,000 for fiscal year ending September 30, 1989.

4. PROJECT GRANTS AND CONTRACTS SHOULD BE CONTINUED FOR THE ALLIED HEALTH PROFESSIONS TO MEET THE NEEDS OF ESTABLISHED NATIONAL PRIORITIES AND TO HELP BUILD THE CAPABILITY FOR LEADERSHIP AND INNOVATION

The case for continued federal activity on behalf of allied health personnel is predicated on the (1) potential health care cost savings through more effective personnel utilization, (2) lack of resources for research, development and demonstration of improvements in training in personnel, and (3) value to states and to the private sector of a federal focal point for allied health personnel activity.

Modest but sharply focused federal initiatives are needed to ensure effective use of allied health personnel. As is the case with the entire health care system, there is an important federal role crucial to the issues of quality assurance, cost containment, geographic and specialty distribution, minority representation, care for the aged, terminally ill and bilingual groups and equal access to health care. Because of the dynamic nature of health care delivery and rapidly changing practice needs, allied health education must not remain static. It is essential to develop the capability for leadership and innovation. Support is needed for activities on which future improvements in allied health education and services are dependent.

We are therefore requesting the following legislative action:

1. Section 795 be repealed.
2. Section 796 be amended at attached hereto.
3. Section 797 be allowed to expire.

Project Grants and Contracts

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Section 796 is amended to read as follows:

(a) The Secretary in accordance with established national priorities, shall make grants to and enter into contracts with eligible entities to assist them in meeting the costs of planning, developing, demonstrating, operating, and evaluating projects related to:

(1) Methods for increasing the efficiency and reducing the costs of health care delivery through more effective use of allied health personnel.

(2) Continuing education (competency updating, faculty development and advanced training) for allied health professionals.

(3) Appropriate retraining opportunities for allied health personnel who, after periods of professional inactivity, desire again actively to engage in the practice or teaching of their allied health profession.

(4) Improving the distribution and availability by geographic area or by specialty group of adequately trained allied health personnel needed to meet the health needs of the Nation, including the need to increase the availability of primary care services, services to the elderly, services to bilingual groups and the need to promote preventive health care.

(5) Providing training and education to upgrade the skills of allied health assistants and other subprofessional allied health personnel, as designated by the Secretary, employed in acute, chronic, and long-term care institutions.

(6) Educational programs which permit individuals to become proficient in a related specialty.

(7) Ways to meet changing needs in health care delivery with out creating new allied health occupations or specialities.

Contracts may be entered into under this subsection without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(b) "The term 'Allied Health Professional' means an individual trained at the associate, baccalaureate, master's, or doctoral degree level in health care related science, with responsibility for the delivery of health care or health care related services (including services related to the identification, evaluation and prevention of diseases and disorders, dietary and nutrition services, health promotion, rehabilitation, and health systems management), but who are not graduates of schools of medicine, optometry, podiatry, pharmacy, or nursing."

(c) The term 'school of allied health' means a regionally accredited public or nonprofit private two-year college, senior college, or university --

(1) which provides, or can provide professionally accredited programs of education in a discipline of allied health leading to an associate or baccalaureate degree or to a more advanced level;

(2) which provides training for not less than a total of twenty persons in the allied health curricula; and

(3) which includes or is affiliated with a teaching hospital.

(d) The Secretary may, with the advice of the National Advisory Council on Health Professions Education, provide assistance to the heads of other departments and agencies of the Government to encourage and assist in the utilization of medical facilities under their jurisdiction for allied health training programs.

(e) No grant or contract may be made under this section unless an application thereof has been submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Health Professions Education. Such an application shall provide for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this section.

(f) For payments under grants and contracts under this section there are authorized to be appropriated $10,000,000 for fiscal year ending September 30, 1985, $10,000,000 for fiscal year ending September 30 ,1986, $10,000,000 for fiscal year ending September 30, 1987, $10,000,000 for the fiscal year ending September 30, 1988, and $10,000,000 for the fiscal year ending September 30, 1989.

In addition, our concern for equitable opportunities for all to enter occupations of their choosing stresses the need for loan opportunities for graduate students in the allied health professions--the majority of whom are women. Thus, we encourage the following two recommendations as well:

5. ELIGIBILITY UNDER THE HEALTH EDUCATION ASSISTANCE LOAN (HEAL) AND HEALTH PROFESSIONS STUDENT LOAN (HPSL) PROGRAMS SHOULD BE EXTENDED TO INCLUDE GRADUATE STUDENTS OF ALLIED HEALTH.

Federal reductions in all student support programs, especially for graduate students, have coincided with dramatic increases in tuition costs. Between 1969 and 1981, graduate tuition and fees more than tripled, with average annual increases of about ten percent. During the same period, private institutions raised their tuition and fee levels nearly five-fold, with average annual increases of approximately 12 percent.

While a number of traditional student aid programs — College Work Study (CWS), Guaranteed Student Loans (GSL) and National Direct Student Loans (NDSL) — have helped students meet the cost of graduate study, there are still significant numbers of graduate students who have no resource to fall back on to finance their education (either through lack of qualification for these programs, or because of overexpended loan programs). Occupational therapy program directors alone estimate that 90 percent of students in private universities and 60-75 percent of students in lower tuition programs need loan assistance. An alternative to these traditional sources of aid would be to include students of allied health under the Health Education Assistance Loan (HEAL) and Health Professions Student Loan (HPSL) programs.

To date, eligibility for the HPSL program has been open exclusively to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry and pharmacy (MODVOPPs). Similarly, the HEAL program is available to the MODVOPPs, however, with the advent of the Omnibus Budget Reconciliation Act of 1981, HEAL was expanded to include students of chiropractic medicine and graduate clinical psychology. The 1981 amendments also enabled graduate students of schools of public health and health administration to apply for HPSL benefits.

Changes in health care practice brought about by advanced technology, a more comprehensive understanding of the human system, and cost containment efforts place increasingly more complex demands on therapists, technologists and certain related disciplines. As more is demanded of the practitioner, more is also required of the educational system. To this end, more of the allied health professions will require education and training at the post-baccalaureate level.

According to a survey of allied health collegiate programs conducted by the American Society of Allied Health Professions in 1980, 337 schools offered an aggregate of 1,471 graduate and doctoral level programs. Graduate programs were found among the following occupations: speech-language pathologists/audiologist, biomedical engineer, corrective therapist, dietitian/nutritionist, environmental health engineer, environmentalist, exercise physiologist, health educator (community/school), health services administrator, occupational therapist, physical therapist, recreation therapist, and rehabilitation counselor.

There are approximately 19,305 students in graduate and doctoral programs in allied health schools. The average tuition is $5,000 per year. If these loans and grants became available, it is probable that for the academic year 1985-86, 25 percent of the students would be interested in HPSL loans of $2,200 per year. Perhaps 5 percent of the student population would desire a HEAL loan. Requested appropriation for graduate students in allied health under the HEAL and HPSL programs are $7.3 million and $10.6 million respectively per fiscal year.

Graduate education in the allied health professions should be an integral component in the continuum of health professions education. While graduate education takes different forms and serves different purposes in the health professions, it is primarily directed toward preparation for practice and may be required for licensure. In addition, it is intimately connected to the preparation of faculty, researchers, and administrators and the development of new knowledge. To this end, the primary goal is to develop experts with the appropriate knowledge, skills and attitudes in a special area.

Stability in graduate education is seriously undermined when federal support is unreliable or fluctuates. Unless adequate student aid is available, the nation will not be able to attract the talented young people it needs into graduate programs of allied health. Therefore, we recommend that eligibility under the HEAL and HPSL programs be extended to include graduate students of allied health.

STUDENT ASSISTANCE

Proposed amendment to the Public Health Service Act as amended by Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981.

Limitations on Individual Federally Insured Loans and on Federal Loan Insurance

Section 729 is amended to read as follows:

(a) The total of the loans made to a student in any academic year or its equivalent (as determined by the Secretary which may be covered by Federal loan insurance under this support may not exceed $20,000 in the case of a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry; $12,500 in the case of a student enrolled in a school of pharmacy, public health, or chiropractic, or a graduate program in health administration or clinical psychology; or $5,000 in the case of a student enrolled in a graduate program in allied health. The aggregate insured unpaid principal amount for all such insured loans made to any borrower shall not at any time exceed $80,000 in the case of a borrower who is or was a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry; $50,000 in the case of a borrower who is or was a student enrolled in a school of pharmacy, public health, or chiropractic, or a graduate program in health administration or clinical psychology; and $20,000 in the case of a borrower who is or was a student enrolled in a graduate program in allied health. The annual insurable limit per student shall not be exceeded by a line of credit under which actual payments by the lender to the borrower will not be made in any year in excess of the annual limit.

Definitions: Student Assistance

Section 737 is amended to read as follows:

"(1) The term 'eligible institution' means, with respect to a fiscal year, a school of medicine, osteopathy, dentistry, veteriuary medicine, optometry, podiatry, pharmacy, public health or chiropractic, or a graduate program in health administration, clinical psychology or allied health."

"(4) The term 'graduate program in allied health' means a graduate program in a public or nonprofit private institution in a State which provides training leading to a post-baccalaureate credential in allied health or an allied health discipline, and which is accredited in the manner described in Section 701(10)."

Loan Agreements for Establishment of Student Loan Funds

Section 742 is amended to read as follows:

(a) The Secretary is authorized to enter into an agreement for the establishment and operation of a student loan fund in accordance with this subpart with any public or other nonprofit school of medicine, osteopathy, dentistry, pharmacy, podiatry, optemetry, veterinary medicine or allied health located in a State and is accredited as provided in Section 293a(b)(1)(B) of this title.

Terms and Conditions

(b) Each agreement entered into under this section shall--

(1) provide for establishment of a student loan funded by the school;

(2) provide for deposit in the fund of (A) the Federal capital contributions to the fund (B) an amount equal to not less than one-ninth of such Federal capital contributions, contributed by such institution, (C) collections of principal and interest on loans made from the fund, (D) collections pursuant to Section 294(a)(j) of this title, and (E) any other earnings of the fund;

(3) provide that the fund shall be used only for loans to students of the school in accordance with the agreement and for costs of collection of such loans and interest thereon;

(4) provide that loans may be made from such fund only to students pursuing a full-time course of study at the school leading to a degree of doctor or medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equivalent degree doctor of podiatry or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, or a post-baccalaureate credential in allied health;

(5) provide that the school shall advise, in writing, each applicant for a loan from the student loan fund of the provisions of Section 294(n) of this title under which outstanding loans from student loan fund may be paid (in whole or in part) by the Secretary; and

(6) contain such other provisions as are necessary to protect the financial interests of the United States.

Loan Provisions

School Year Limitation

(a) Loans from a student loan fund (established under an agreement with a school under Section 294m of this title) may not exceed for any student for each school year (or its equivalent) the sum of --

(1) the cost of tuition for such year at such school, and

(2) $2,500

School Determination of Terms and Conditions; Needy Students Eligible

(b) Any such loans shall be made on such terms and conditions as the school may determine, but may be made only to a student in need of the amount thereof to pursue a full-time course of study at the school leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equivalent degree, doctor of podiatry or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree or a post-baccalaureate credential in allied health.

Repayment in Periodic Installments; Acceleration; Commencement and Duration of Period; Exclusions from Period

(c) Such loans shall be repayable in equal or graduated periodic installments (with the right of the borrower to accelerate repayment) over the ten year period which begins one year after the student ceases to pursue a full time course of study at a school of medicine, osteopathy, dentistry, pharmacy, podiatry, optometry, veterinary medicine or allied health, excluding from such ten year period all periods (up to three years) of (1) active duty performed by the borrower as a member of a uniformed service, or (2) service as a volunteer under the Peace Corps Act; and periods of advanced professional training including internships and residencies).

Cancellation of Liability for Repayment

(d) The liability to repay the unpaid balance of such a loan and accrued interest thereon shall be canceled upon the death of the borrower, or if the Secretary determines that he has become permanently and totally disabled.

Interest

(e) Such loans shall bear interest, on the unpaid balance of the loan, computed only for periods for which the loan is repayable, at the rate of 9 percent per year.

Payment of Principal and Interest for Practice in Physician, etc., Shortage Areas; Limitation; Liability for Reimbursement; Election of Loan Cancellation under Amended or Original Provisions

(f)(1) In the case of any individual --

(A) who has received a degree of doctor of medicine, doctor of osteopathy, doctor of dentistry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, doctor of optometry or an equivalent degree, bachelor of science in pharmacy or an equivalent degree doctor of podiatry or an equivalent degree, or a post-baccalaureate credential in allied health.

(B) who (i) obtained one or more loans from a loan fund established under this subpart, or (ii) obtained, under a written loan agreement entered into before October 12, 1976, any other educational loan for his costs at a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or allied health; and ....

6. EXCEPTIONAL FINANCIAL NEED SCHOLARSHIPS SCHOULD BE MADE AVAILABLE TO GRADUATE STUDENTS ATTENDING SCHOOLS OF ALLIED HEALTH.

Students in health professions education are bearing an increasing financial burden because of the increase in tuition and fees at many schools and the decrease in student financial aid. There is a decrease in both external funding of financial aid and of scholarships and loan funds controlled by the schools themselves. Concern has been expressed about how the increase in educational costs to students will affect the composition of applicant pools and of classes, as well as how it will affect the choice of profession, specialty, and practice location.

Qualified students should have an equal chance of entering the health professions, regardless of their financial background. Further, the health professions should be representative of all races and socioeconomic groups in the U.S.; there is some evidence that such wide representation will improve the overall quality of health care. Some studies have indicated that students tend to work or practice in the geographic area and the urban or rural settings where they grow up. Thus, careful student recruiting may serve as a means of providing health care to isolated or underserved areas.

Qualified students may make adjustments in their career selection based on their ability to pay tuition and to meet living costs, particularly if they are unwilling to incur substantial educational debt. It is entirely possible that many qualified people do not apply to health professions education program for financial reasons.

To date, schools of medicine, osteopathy, dentistry, opteometry, pharmacy, poidatry, and veterinary medicine have been awarded federal grants so that they may extend scholarships to to first-year graduate students of exceptional need. There are a substantial number of graduate students in allied health programs as well (over 19,000 in 1980), many of which could profit from this program. therefore, we strongly recommend that the scholarship program for first-year students of exceptional financial need be extended to include schools of allied health.

Scholarships for First Year Students of Exceptional Financial Need

Proposed amendment to the Public Health Service Act is amended by Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981.

Section 758 is amended to read as follows:

(a) The Secretary shall made grants to a public nonprofit school of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine or allied health which is accredited as provided in Section 293(a)(b)(1)(B) of this title for scholarships to be awarded by the school of full-time students thereof who are of exceptional financial need and who are in their first-year of study at such school.

CONCLUSIONS

If allied health services are essential to the well-being of the nation, then allied health education is equally essential. Allied health services depend on allied health education. The informally and haphazardly prepared health practitioner might have suited the level of sophistication of health care delivery at the turn of the century; today, the knowledge and skills required to perform health services are much more advanced. Formal education programs for most allied health professions are the only means of ensuring that a sufficient number of personnel will be adequately prepared. In addition, eligibility under all student aid and scholarship programs is essential to enable students to access formal education programs. Although, some individuals may be able to acquire the necessary knowledge and skills by other means, most will require formal post-secondary preparation ranging from short-term training to graduate study.

Moreover, the continued improvement of allied health services -- in terms of quality, cost effectiveness, access, and continuity -- depends on allied health education. Without advanced programs and formal leadership development, it unlikely that the necessary research and development activities will be conducted. These research and development activities can lead to improvement in services directly and also indirectly by improving educational processes which in turn lead to better prepared practitioners. The future of health services and health service delivery depends on financial support for allied health education and a renewed commitment on the part of the federal government to provide its fair share of that support.

I appreciate the opportunity to submit these comments on behalf of the American Society of Allied Health Professions. If you have any questions, or need further clarification, please feel free to contact Carolyn M. Del Polito, Ph.D., Executive Director of ASAHP at (202)857-1150.

Sincerely,

Polly A. Fitz

Polly A. Fitz, M.A.
President

PAF/tah

ENDORSING ORGANIZATIONS

American Art Therapy Association
American Dental Hygienists' Association
American Dietetic Association
American Medical Association
American Medical Record Association
American Medical Technologists
American Occupational Therapy Association
American Physical Therapy Association
American Society of EEG Technologists
American Association of Bioanalysts
American Society for Medical Technology
American Speech-Language-Hearing Association

Statement of the

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Regarding Reauthorization of

The Health Professions Educational Assistance Act

Submitted to

COMMITTEE on LABOR and HUMAN RESOURCES

UNITED STATES SENATE

Roger P. Kingsley, Ph.D.
Director
Congressional Relations Division
Governmental Affairs Department

March 19, 1984

The American Speech-Language-Hearing Association (ASHA) is pleased to submit comments regarding reauthorization of the Health Professions Educational Assistance Act (Public Law 94-484), Title VII of the Public Health Service Act.

ASHA is the professional society representing over 39,000 speech-language pathologists and audiologists nationwide. These education and health professionals are concerned with the systems, structures and functions that make human communication possible; with the causes and effects of abnormalities in human communication; and with the identification, evaluation and treatment of individuals with speech, language and hearing disorders.

Speech-language pathologists and audiologists have graduate training that leads to a Master's or Doctoral degree and the awarding of a Certificate of Clinical Competence (CCC) in their area of specialization. Speech-language pathologists and audiologists render professional services in metropolitan and rural areas and in such settings as hospital speech and hearing clinics, outpatient rehabilitation centers, home health care agencies, public and private schools, and in private practice. The ASHA CCC is recognized by the Department of Health and Human Services as the appropriate certificate for provision of Medicare and Medicaid services.

Communication handicaps represent one of the most chronic and disabling conditions in the United States. These disorders are prevalent among all races, socioeconomic classes, and age groups, although speech and language disorders are more commonly found in children and hearing disorders are more prevalent in the elderly population. According to U.S. Census data for 1980, there were approximately 2.6 million speech and language impaired persons and over 18 million hearing impaired persons in the nation.[1] However, as a result of an increase in the number of surviving handicapped infants and the disproportionate growth in the aging population, both types of handicaps are projected to increase dramatically during the rest of this century and beyond. By the year 2025, it is estimated that there will be over 3.6 million speech/language impaired and 32.6 million hearing impaired Americans.[2]

These data and trends make evident the need for an adequate work force of qualified professionals to serve the communicatively impaired population. However, various studies indicate a serious shortage of available professionals in the field. A report by the Bureau of Health Manpower, Health Resources Administration found that "at least three or four times more speech pathologists are needed and approximately four times as many audiologists are needed to provide required services...it appears that the supply of speech pathologists and audiologists is not adequate to meet either current or future demands and needs."[3] (See Appendix A)

Most federal support for graduate training of speech, language and hearing professionals has been through the personnel development programs under the jurisdiction of the Office of Special Education and Rehabilitative Services (as authorized by the Education of the Handicapped Act and the Rehabilitation Act of 1973, as amended). Little support has been derived in recent years through programs under the Public Health Service Act. About 16 percent of graduate speech, language, and hearing programs are in schools of allied health. The remainder are in schools of liberal arts, education and medicine. (See Appendix B) Also, unlike allied health professions, the speech, language and hearing profession is not prescription based. Medicare and other federal statutes recognize that their advanced training and the specialized services they provide qualify speech-language pathologists and audiologists as capable of developing plans of treatment for their patients independent of physician involvement.

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[1] U.S. Bureau of the Census. 1982a Preliminary Estimates of the Population of the United States: 1970 to 1981.

[2] U.S. Bureau of the Census. 1982b Projections of the Population of the United States: 1982 to 2050.

[3] Bureau of Health Manpower, Health Resources Administration, A Report on Allied Health Personnel (November 1979), p. XIV-5.

The foregoing problems concerning population trends, work force supply and federal support for health care professionals point to a number of areas in the Health Professions Educational Assistance Act that are in need of modification. In making the following recommendations, ASHA reaffirms its endorsement of some of the proposals presented to this Committee by the American Society of Allied Health Professions (ASAHP).

The Definition of Allied Health Personnel

ASHA is particularly concerned with the inadequate and inappropriate definition contained in Part G, Section 795 of the Act. This definition refers to "allied health personnel" as

> individuals with training and responsibilities for (A) supporting, complementing, or supplementing the professional functions of physicians, dentists and other health professionals in the delivery of health care to patients.

This definition fails to recognize the range of health care functions performed by non-physician health professionals. Whatever the past validity of allied health professionals as personnel who assisted physicians, current reality is that many of these professionals function in more of a collaborative than supportive role. This is certainly true for speech-language pathologists and audiologists whose advanced training and specialized practices make any characterization as supportive personnel derogatory as well as fallacious. In its Report on the Omnibus Reconciliation Act of 1980, the House Committee on Ways and Means recognized the proper role of speech-language pathology in the Medicare delivery system:

> Since speech-language pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services. As a result, your Committee's bill allows either the physician or the speech pathologist to establish the plan of treatment so as to conform Medicare law and program policy to actual practice among the professions. (H. Rpt. 96-588)

Because of the subservient connotations of the present definition of allied health, members of this and other disciplines often refer to themselves as independent health professionals. We believe that, in order to be an accurate and acceptable term, "allied health" should connote a horizontal alliance rather than a vertical linkage with the medical professions.' Therefore, we recommend that the existing definition be repealed and replaced with the following new definition:

> The term "Allied Health Professional" means an individual trained at the associate, baccalaureate, master's or doctoral degree level in health care related science, with responsibility for the delivery of human health care and health care related services (including services related to the identification, evaluation and prevention of diseases and disorders, dietary and nutrition services, health promotion, rehabilitation, and health systems management), but who are not graduates of schools of medicine, optometry, podiatry, pharmacy, or nursing.

Data on Health Professions

ASHA believes that data are needed to document the supply of existing allied health professionals and to project future needs relevant to the proper utilization of such professionals for a changing population. Congress recognized the need for accurate and current data on health professions in P.L. 94-484, and reaffirmed this need in reauthorizing the Act in 1981 (P.L. 97-35).

Pursuant to the Act, the Health Resources Administration issued its report stating:

> There are insufficient data about allied health personnel at the local, state, or national level to permit radical improvements in planning, production, and management. The large number of occupations and functions involved, and their interrelations, makes good planning for allied health personnel difficult. Improved data on production, recruitment, reimbursement, utilization, service costs, and work force quality are needed... Data on improvements in supply, work-force quality, educational standards and methods, and opportunities for minorities are difficult and costly to produce and generally less than satisfactory. Where improvements have occurred, federal support appears to be a decisive factor.[4]

A report issued by the National Commission on Allied Health Education reached a similar conclusion:

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[4] A Report on Allied Health Personnel, XVII-4.

> The federal government should support the systematic and continuous collection and dissemination of data on the numbers and distributions of health manpower in all occupational areas, including information on projected openings. Support also should be made available for the continuation of biennial national inventories of allied health programs, expanded to include all settings which continue to offer formal post-secondary education programs.[5]

In 1980, the Senate Committee on Labor and Human Resources found that data collection relating to the allied health field was seriously lagging relative to the information that had been compiled for medicine and dentistry. The Committee called for "similar attention to be directed to nursing and to the allied health professions." In addition, the Committee looked to the Department of Health and Human Services to ensure that future reports would include information on the status of underrepresented groups including minorities, women, and the handicapped." (Senate Report 96-936.)

Current data needs are only being partially met. The Department of Education collects data relating to personnel in the schools and in vocational rehabilitation settings. However, information on the supply, location and adequacy of personnel in the broad health care delivery system is generally limited to individual professional disciplines. Few allied health professions have the resources for such sophisticated data collection. Even when they undertake such data gathering and analysis efforts, their conclusions are often given scant attention and credibility. What is needed in order to adequately gauge future health profession needs and to assist in creating a balance among personnel, beneficiaries, and delivery systems is a nationwide data collection effort that is supported with adequate federal funds.

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[5] The National Commission on Allied Health Education, The Future of Allied Health: Alliances for the 1980s.

Section 708 of the Act should be amended as follows in order to strengthen the data base for all health professions:

> (a) The Secretary shall establish a program, including a uniform health professions data reporting system, to collect, compile, and analyze data on health professions personnel which shall include data respecting physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, public health personnel, audiologists, speech-language pathologists, health care administration personnel, nurses, allied health personnel, medical technologists, chiropractors, clinical psychologists, and any other health personnel in states designated by the Secretary to be included in the program. Such data shall include data respecting the training, licensure status (including permanent, temporary, partial, limited, or institutional), place or places of practice, profession specialty, practice characteristics, place and date of birth, sex, and socio-economic background of health professions personnel and such other demographic information regarding health professions personnel as the Secretary may require.
>
> (b) In carrying out subsection (a), the Secretary shall collect available information from public or private entities. The Secretary may make grants to and enter into contracts with public and private entities for the collection of information not otherwise available.
>
> (c) The Secretary, in cooperation with appropriate public and private entities, shall
>
> (1) analyze or provide for the analysis of health personnel data collected under this section;
>
> (2) conduct or provide for the conduct of

> (A) analytic and descriptive studies of health personnel information including the need for, and supply of, health personnel; and (B) projections relating to such need and supply in the future, compiled according to type of personnel, practice specialty, and geographic location; and
>
> (3) conduct or provide for the conduct of analytic and descriptive studies of information on health students, interns, residents and practitioners who are participating in health professions education, and on health education programs and institutions, including institutional resources, student financial requirements and indebtedness, student characteristics such as age, sex, race, ethnicity, and socio-economic background, and apparent career choices such as practice specialty and geographic location.

The National Advisory Council on Health Professions Education

Allied and other non-physician health professionals comprise approximately three-fifths of the total health work force which now numbers over five million. The non-physician sector is also growing at a much greater rate than the physician community, in part because of the increased recognition of the need for and cost effectiveness of these professionals. It is only reasonable, then, to require that health education planning include at least one representative of an allied health profession (as the term is redefined) program. Section 701(a) of the Act should therefore be amended to read:

> There is established in the Public Health Service a National Advisory Council on Health Professions Education (hereafter in this section referred to as the "Council"), consisting of the Secretary (or his delegate), who shall be Chairman of the Council, and twenty members appointed by the Secretary...from persons who because of their education, experience, or training are particularly qualified to advise the Secretary with respect to the programs of assistance authorized by parts B, C, D, E, F, and G of this

> subchapter. Of the appointed members of the Council twelve shall be representatives of health professions schools and allied health professions educational programs, including at least one representative each of schools of veterinary medicine, optometry, pharmacy, and podiatry, at least one representative of an allied health professions educational program, and at least one representative of schools of public health and graduate programs in health administration...

A New Authority for Assistance to Disadvantaged Individuals

Individuals from disadvantaged backgrounds, particularly racial and ethnic minorities have historically been underrepresented as beneficiaries of health services and as providers of these services. Studies have shown that minority students are underrepresented in both undergraduate and graduate allied health education programs. A 1980 survey conducted by ASAHP showed that Black students accounted for only eight percent and Hispanic students only three percent of undergraduate and graduate allied health programs. Only about four percent of current speech-language pathologists and audiologists nationally are racial minorities, and it is estimated that there is only one minority speech-language pathologist or audiologist for every 4,466 persons with communication disorders.[6] The National Council on Graduate Programs in Communication Sciences and Disorders reports that minority students represent 10 percent of the enrollment in speech, language and hearing programs, so the present trend is toward an increase in minority professionals. (See also Appendix C.)

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[6] American Speech-Language-Hearing Association, Speech-Language Pathology and Audiology: Career Information for Minority Students.

Health profession careers offer an excellent avenue of social and economic mobility for disadvantaged students, particularly since the employment outlook is favorable in many of these occupations. Also, increasing the number of minority health professionals should bring gains in services to those underserved populations that are bilingual-bicultural and found in urban and rural areas which lack adequate numbers of qualified health professionals.

We recommend that Section 798 of the Act be modified as follows:

(a)(1) For the purpose of assisting individuals who, due to socioeconomic factors, are financially or otherwise disadvantaged (including minority and handicapped individuals and individuals who are veterans of the Armed Forces with military training or experience in the health field) to undertake education to enter the allied health professions, the Secretary shall make grants to and enter into contracts with schools of allied health, State and local educational agencies, and other public or private nonprofit entities to assist in meeting the costs described in paragraph (2).

(2) A grant or contract under paragraph (1) may be used by the school, agency, or entity to meet the costs of --

(A) identifying, recruiting, selecting, and retraining such individuals; (B) facilitating the entry of such individuals into schools of allied health professions; (C) providing counseling or other services and studies designed to assist such individuals to complete successfully their education in an allied health profession; (D) providing, for a period prior to the entry of such individuals into the professional program of education at an allied health professions school, preliminary education designed to assist them to complete successfully such allied health professional education.

(b)(1) No grant may be made or contract entered into under subsection (a) unless an application therefore has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) The amount of any grant under subsection (a) shall be determined by the Secretary.

(c) For payments under grants and contracts under subsection (a) there are authorized to be appropriated $3,000,000 for fiscal year ending September 30, 1985, $3,000,000 for fiscal year ending September 30, 1986, $3,000,000 for fiscal year ending September 30, 1987, $3,000,000 for fiscal year ending September 30, 1988, and $3,000,000 for fiscal year ending September 30, 1989.

Graduate Student Eligibility Under the HEAL and HPSL Programs

Currently, graduate students in allied health programs are not eligible for assistance under the Health Education Assistance Loan (HEAL) and Health Professions Student Loan (HPSL) Programs. Eligibility for assistance in these programs has been limited to students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry and pharmacy (MODVOPPs), although the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) expanded the HEAL program to include graduate students in chiropractic medicine, clinical psychology, public health and health administration.

A graduate degree is required for certification and licensure (in 35 states with licensure laws) in speech-language pathology and audiology. As more states require that stricter education and training standards be applied to health, education and rehabilitation service providers, other professions are raising their minimal educational requirements. This trend toward more post-baccalaureate education in a time of rising education costs make it imperative that new sources of assistance be made available to allied and other non-physician health profession students.

We recommend that Sections 737 and 742 of the Act be amended to include the eligibility of graduate students in allied health as they are defined in the revised definition set forth in the first recommendation of this statement.

Federal Financial Support for Allied Health Education

A strong federal role in supporting allied health programs is essential. As mentioned earlier, this non-physician sector comprises a majority of all health care providers. Because these professionals provide their services at much lower cost than do members of the medical professions, any support that will expand their services has significant ramifications for cost control in the health care system as a whole.

In the current fiscal year, only $800,000 (or about four percent) of a total health manpower appropriation of $198.4 million was allocated to allied health education. Federal support needs to be increased to help health professions education programs graduate an adequate supply of qualified allied health professionals to meet the future health care needs of society - in terms of quality, access and cost effectiveness.

In order to improve the future of health professions education and services, we recommend modification of Section 796 as follows:

(a) The Secretary in accordance with established national priorities, shall make grants to and enter into contracts with eligible entities to assist them in meeting the costs of planning, developing, demonstrating, operating, and evaluating projects related to:

(1) Methods for increasing the efficiency and reducing the costs of health care delivery through more effective use of allied health professionals.

(2) Continuing education (competency updating, faculty development and advanced training) for allied health professionals.

(3) Appropriate retraining opportunities for allied health professionals who, after periods of professional inactivity, desire again to actively engage in the practice or teaching of their allied health profession.

(4) Improving the distribution and availability by geographic area or by specialty group of adequately trained allied health professionals needed to meet the health needs of the Nation, including the need to increase the availability of primary care services, services to the elderly, services to bilingual groups and the need to promote preventive health care.

(5) Providing training and education to upgrade the skills of allied health assistants and other subprofessional allied health personnel, as designated by the Secretary, employed in acute, chronic, and long-term care institutions.

(6) Educational programs which permit individuals to become proficient in a related specialty.

(7) Ways to meet changing needs in health care delivery without creating new allied health occupations or specialties.

(b) The term "Allied Health Professional" means an individual trained at the associate, baccalaureate, master's or doctoral degree level in health care related science, with responsibility for the delivery of human health care and health care related services (including services related to the identification, evaluation and prevention of diseases and disorders, dietary and nutrition services, health promotion, rehabilitation, and health systems management), but who are not graduates of schools of medicine, optometry, podiatry, pharmacy, or nursing.

(c) The term 'school of allied health' means a regionally accredited public or nonprofit private two-year college, senior college, or university --

(1) which provides, or can provide professionally accredited programs of education in a discipline of allied health leading to an associate or baccalaureate degree or to a more advanced degree;

(2) which provides training for not less than a total of twenty persons in the allied health curricula; and

(3) which includes or is affiliated with a teaching hospital.

(d) The Secretary may, with the advice of the National Advisory Council on Health Professions Education, provide assistance to the heads of other departments and agencies of the Government to encourage and assist in the utilization of medical facilities under their jurisdiction for allied health training programs.

(e) No grant or contract may be made under this section unless an application thereof has been submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Health Professions Education. Such an application shall provide for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this section.

(f) For payments under grants and contracts under this section there are authorized to be appropriated $10,000,000 for fiscal year ending September 30, 1985; $10,000,000 for fiscal year ending September 30, 1986; $10,000,000 for fiscal year ending September 30, 1987; $10,000,000 for the fiscal year ending September 30, 1988; and $10,000,000 for the fiscal year ending September 30, 1989.

The American Speech-Language-Hearing Association appreciates the Committee's consideration of the information, views and recommendations presented in this statement. We look forward to working with you on this important legislation.

Table 3. Clinical Manpower Needs for Audiologists Compared to Manpower Resources, 1973-1985

Forecast for the period	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Audiological service needs:													
Screening (infants)	733	739	746	752	758	765	771	777	783	790	796	802	809
Screening (3-18)	777	776	775	774	773	772	771	769	768	767	766	765	764
Habilitation (3-18)	4998	4990	4983	4976	4968	4961	4954	4946	4939	4932	4924	4917	4910
Hab. severely impaired (3-18)	5831	5822	5814	5805	5796	5788	5779	5771	5762	5754	5745	5736	5728
Testing medical purposes	3047	3079	3112	3144	3177	3210	3243	3275	3308	3341	3373	3406	3439
Rehabilitation (adults)	3483	3537	3591	3645	3700	3754	3808	3862	3916	3971	4025	4079	4133
Testing in industry	96	96	96	96	96	96	96	96	96	96	96	96	96
Total need	18965	19039	19117	19193	19268	19346	19422	19496	19572	19651	19725	19801	19879
Audiology workforce resources:													
Continuing audiologists	2330	2565	2819	3094	3390	3706	4043	4401	4779	5178	5597	6038	6498
New audiologists													
B.S. graduates	68	73	77	82	86	91	95	100	104	108	113	117	122
M.S. graduates	345	373	401	429	457	485	513	541	569	597	625	653	681
Ph.D. graduates	7	7	8	8	9	9	10	10	11	11	12	12	13
Attrition	144	154	163	172	181	190	199	208	217	226	235	244	253
Inactive	41	45	48	51	55	58	61	65	68	71	74	78	81
Projected supply of audiologists	2565	2819	3094	3390	3706	4043	4401	4779	5178	5597	6038	6498	6980
Net need	16400	16220	16023	15803	15562	15303	15021	14717	14394	14054	13687	13303	12899

Source: Speech Pathology and Audiology: Manpower Resources and Needs. Washington, D.C.: Government Printing Office, 1977.

Table 4. Clinical Manpower Needs for Speech Pathologists Compared to Manpower Resources, 1973-1985

Forecast for the period	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Speech pathology service needs:													
Screening (3-18)	518	517	517	516	515	514	514	513	512	511	511	510	509
Habilitation (3-18)	62971	62879	62786	62693	62601	62508	62416	62323	62230	62138	62045	61952	61860
Habilitation and testing (adults)	3242	3292	3343	3393	3444	3494	3545	3595	3646	3696	3747	3797	3847
Hab. severely hearing impaired	3831	3822	3814	3805	3796	3788	3779	3771	3762	3754	3745	3736	3728
Total need	72562	72510	72460	72407	72356	72304	72254	72202	72150	72099	72048	71995	71944
Speech pathology workforce resources:													
Continuing speech pathologists	18377	20226	22223	24168	26662	29103	31692	34430	37316	40349	43530	46860	50338
New speech pathologists													
B.S. graduates	2214	2358	2301	2845	2788	2932	3073	3219	3362	3506	3649	3791	3936
M.S. graduates	1684	1821	1957	2094	2231	2368	2305	2642	2778	2915	3052	3189	3326
Ph.D. graduates	34	36	39	41	43	45	48	50	52	54	57	59	61
Attrition	1690	1797	1903	2009	2115	2222	2328	2414	2580	2647	2753	2859	2965
Inactive	391	421	449	477	506	534	362	591	619	647	675	704	732
Projected supply of speech pathologists	20226	22223	24168	26662	29103	31692	34430	37316	40349	43530	46860	50338	53964
Net need	52336	50287	48292	45745	43253	40612	37824	34886	31801	28569	25188	21657	17980

Source: Speech Pathology and Audiology: Manpower Resources and Needs. Washington, D.C.: Government Printing Office, 1977.

APPENDIX B

Profile of Educational Programs in Speech-Language Pathology and Audiology

Jerry L. Punch and David J. Fein

Introduction

Results of surveys of educational programs in speech-language pathology and audiology have been reported regularly in *Asha* since the early 1960s. Minimally, the surveys have yielded estimates or actual counts of speech-language pathology and audiology enrollees and graduates of American colleges and universities. These studies are useful in education and health planning, both in assessing the current productivity of educational programs and in establishing a basis for projections of the future professional workforce. The last such survey, conducted in 1978 (Perrin, 1979), revealed a decline in enrollments in graduate programs with respect to the five-year period preceding that study.

The American Speech-Language-Hearing Association (ASHA) is currently engaged in a project to determine the supply of, and demand for, speech-language pathologists and audiologists. As part of this project, we sought to gather descriptive data on a variety of aspects of educational speech-language-hearing programs, including faculty and clinical staff in these programs, the availability of financial assistance for students, and enrollments and graduates.

Methods

The data in this report are based on two mail surveys of educational programs in speech-language pathology and audiology that were conducted in April 1982. One survey questionnaire was used to obtain data for the 1982 *Guide to Graduate Education in Speech-Language Pathology and Audiology* and was sent to all programs offering a graduate degree. These programs were queried with respect to selected characteristics of any existing programs at the undergraduate level, as well as at the graduate level. Intensive follow-up in this "Graduate Program Survey" and the incentive provided by dissemination of program information in the *Guide* resulted in a complete response from the 236 known graduate programs located in the 50 states, the District of Columbia, Puerto Rico, and Canada.

A much shorter questionnaire was mailed to the 69 U.S. programs believed to offer only a bachelor's degree in the speech-language-hearing field (termed hereafter the "Bachelor's-Only Survey"). Results, considering response to the mailing, existing ASHA records, and subsequent comparison with data from the 1982-83 National Survey completed by the Council of Graduate Programs in Communication Sciences and Disorders (1983), revealed that four undergraduate programs were terminated between May 1981 and April 1983. For purposes of this report, it was assumed that the remaining 65 bachelor's-only programs existed at the time of our survey. Only 43 of these 65 programs, or 66%, responded to this survey. As this response rate would lead to substantial underestimates of enrollees and graduates from bachelor's-only programs, the Bachelor's-Only Survey data were weighted by the inverse of the response rate (65/43 = 1.51). The validity of the assumption inherent in the process—that, on the average, responding and nonresponding bachelor's-only programs have the same numbers of enrollees and graduates—could not be ascertained.

Data from both surveys are subject to biases from item nonresponse (as distinct from total nonresponse), since many programs did not complete every item on the questionnaire.

Classification of programs on the basis of degrees offered was inferred from the presence of undergraduate enrollees or graduates for bachelor's programs, and from the presence of applicants or graduates for master's programs. This procedure could have resulted in some misclassification if programs either neglected to report actual applicants, enrollees, and graduates, or reported any of these erroneously. Because programs were asked specifically if they offered doctoral degrees, misclassification is not a concern for data related to doctoral programs.

Data pertain to the 1981-82 academic year ending in August 1982. Because most programs had not concluded the academic year at the time of the survey, respondents were asked to estimate both the numbers of students they expected to graduate by August and by what percentages these estimates might differ from the actual number of graduates. The mean expected deviation of estimates from actual graduates was 7% for the Graduate Program Survey and 9% for the Bachelor's-Only Survey.

Enrollment and graduate figures in this report treat part-time and full-time students equally. Faculty and clinical (nonteaching) staff data, however, are based on full-time equivalencies.

Results

Program Characteristics

Tables 1-3 summarize some key characteristics of speech-language pathology and audiology programs. Tables 1 and 2 present data on the degrees offered by these programs. Specifically, Table 1 shows the number of programs offering various degrees by professional area, while Table 2 reports the programs by combination of degree levels offered.

Table 1 reveals that 89% of the total of 301 programs offer a bachelor's degree and 74% offer a master's in speech-language pathology. While only 48% of programs offer a master's degree in audiology, the percentage offering a doctorate in audiology (17%) is approximately the same as that for programs offering the doctorate in speech-language pathology (15%).

Table 1
Number of responding programs offering various degrees in academic year 1981-82

Degree and Professional Area	Number of Programs	Percentage of Programs*
Bachelor's	266	88.4%
Master's		
Speech-Language Pathology	222	73.7%
Audiology	145	48.2%
Doctorate		
Speech-Language Pathology	54	17.9%
Audiology	50	16.6%
Speech-Language Hearing Science	38	12.6%

*Based on total of 301 programs.

According to Table 2, the vast majority of programs offer either the bachelor's and master's degrees (51%), the bachelor's degree only (22%), or degrees at all three levels (17%). Only 32 programs, or about 11%, are limited to graduate education.

Table 2
Number and percentage of responding programs by combination of degree levels offered in academic year 1981-82

Degree Type	Number of Programs	Percentage of Programs
Bachelor's only	65	21.6%
Master's Only	20	6.6%
Doctorate Only	2	0.7%
Bachelor's & Master's	152	50.5%
Master's & Doctorate	10	3.3%
Bachelor's, Master's & Doctorate	52	17.3%
Total	301	100.0%

Table 3 highlights the diversity of academic divisions in which speech-language pathology and audiology graduate programs are found. Of the 142 programs for which the division setting could be identified, 38% were in liberal arts and sciences divisions of their universities, 22% in schools of education, and 16% in allied health divisions. Another 14% were in communication sciences divisions, medical schools, and special education divisions. An additional 10% fall into a wide range of other university divisions.

Table 3
Number and percentage of responding graduate degree programs by division in which program is located

Division of University	Number of Programs	Percentage of Programs
Liberal Arts & Sciences	54	38.0%
Education	31	21.8%
Allied Health	23	16.2%
Communication Sciences	13	9.2%
Medicine	5	3.5%
Special Education	2	1.4%
Other	14	9.9%
Total Known	142	100.0%
Number Unknown	94	—

Financial Data

The Graduate Program Survey collected information on the projected 1982-83 costs of graduate education and on financial aid provided to graduate students in 1981-82. Tuition costs per hour of academic credit were obtained for resident (in state) and nonresident (out of state) students according to whether the university was operating on a quarter or semester calendar. The numbers and average amounts of graduate fellowships, assistantships, and traineeships were also determined.

Table 4 indicates that mean tuition costs per credit hour for resident and nonresident students were $60 and $104, respectively, in programs operating under a quarterly calendar and were $74 and $118, respectively, under the semester system. Median per credit hour figures were consistently lower than the mean costs for these categories, suggesting the presence of a few very expensive programs. The large standard deviations indicate substantial variation in costs among programs.

Table 4
Projected 1982-83 mean and median tuition costs per academic credit hour by type of credit hour and resident status

	Type of Credit Hour			
	Quarter Hour		Semester Hour	
Statistic	Resident	Nonresident	Resident	Nonresident
Mean Cost	$60	$104	$ 74	$118
Median Cost	41	89	54	100
Standard Deviation	73	24	56	69
N	30	31	155	151

Over 2,100 graduate students received either a fellowship (402), an assistantship (1,154), or a traineeship (549) in 1981-82 (see Table 5). Based on data reported in Table 6, one-quarter of all graduate enrollees received financial assistance in 1981-82. Overall, an estimated $4.6 million in financial assistance was distributed to graduate students in awards, averaging $2,176 per student. The average award was only slightly higher in programs accredited by ASHA's Education and Training Board—ETB—($2,191) than in nonaccredited programs ($2,131).

Table 5
Number and total amount of financial assistance awards to graduate students by type of award in 1981-82

Type of Award	Number of Awards	Total Amount Awarded
Fellowship	402	$ 876,816
Assistantship	1,154	$2,584,436
Traineeship	549	$1,118,668
All Types	2,105	$4,579,920

Enrollees and Graduates

Table 6 shows the number of enrollees and graduates in upper-division undergraduate and graduate programs by individual states. A total of 13,041 undergraduates were enrolled in 1981-82 at the upper-division level, while 7,660 and 742 students were enrolled in master's and doctoral-level programs, respectively. Of the total of 9,866 graduates of educational programs in 1981-82, 5,495 received bachelor's degrees, 4,226 received master's degrees, and 145 were awarded the doctorate. Of those graduating with master's degrees, approximately 85% received degrees in speech-language pathology, with the remaining 15% receiving degrees in audiology. Of the 145 doctoral graduates, 86 received degrees in speech-language pathology, 37 in audiology, and 22 in speech and hearing sciences (not shown in the table).

Table 6

umber of enrollees in and graduates from speech-language pathology and audiology programs in the United States, its territories, nd Canada by academic level and state: academic year 1981-82

tate	Number of Enrollees				Number of Graduates			
	Number of Programs	Bachelor's*	Master's	Doctoral	Bachelor's*	Master's		Doctoral
						Speech-Lang. Pathology	Audiology	
abama	5	182	110	3	114	42	18	0
laska	0	0	0	0	0	0	0	0
rizona	3	251	119	5	94	53	7	1
rkansas	6	153	65	0	95	40	3	0
alifornia	25	1436	737	22	469	336	29	5
olorado	7	184	197	19	117	63	30	8
onnecticut	2	80	47	12	50	52	5	2
elaware	0	0	0	0	0	0	0	0
istrict of Columbia	4	61	96	6	37	32	11	4
lorida	3	342	157	22	91	94	30	6
eorgia	5	63	115	3	13	49	7	2
awaii	1	40	37	0	8	15	1	0
daho	2	8	0	0	14	10	5	0
inois	14	464	439	48	239	208	35	12
ndiana	5	300	427	28	100	40	13	5
wa	3	137	23	0	65	36	8	7
ansas	4	99	105	21	53	81	15	6
entucky	6	140	94	0	66	55	2	0
ouisiana	12	655	138	8	181	45	13	0
aine	2	76	20	0	28	8	0	0
aryland	3	310	156	20	115	56	7	2
assachusetts	6	169	239	13	101	105	17	1
ichigan	9	499	322	27	238	182	31	7
innesota	6	310	101	12	195	52	4	2
ississippi	4	245	65	1	115	38	10	1
issouri	11	323	151	3	160	84	4	3
ontana	1	50	36	0	14	16	5	0
ebraska	3	51	29	5	39	40	2	0
evada	1	60	25	0	12	9	0	0
ew Hampshire	1	86	0	0	41	0	0	0
ew Jersey	8	325	267	0	219	120	13	0
ew Mexico	3	96	73	0	10	8	0	0
ew York	25	1069	626	168	544	325	48	21
orth Carolina	9	292	146	25	123	76	5	0
orth Dakota	3	131	42	0	48	34	0	0
hio	10	682	353	49	237	162	47	10
klahoma	7	169	117	22	79	48	6	4
regon	5	155	77	7	41	38	11	2
ennsylvania	14	635	273	16	335	161	29	6
hode Island	1	70	40	0	18	14	3	0
outh Carolina	4	106	89	0	45	50	3	0
outh Dakota	3	110	32	0	52	14	5	0
ennessee	6	236	198	33	39	73	42	8
exas	19	815	443	66	357	153	28	4
tah	3	172	66	14	84	32	21	4
ermont	1	16	20	0	6	18	3	0
irginia	6	229	142	8	124	66	17	1
ashington	7	347	188	25	112	95	22	3
est Virginia	1	112	42	1	48	20	12	1
isconsin	7	444	257	30	166	162	13	5
yoming	1	60	23	0	12	6	2	0
uerto Rico	1	0	38	0	0	16	0	0
anada	3	27	40	0	26	32	12	0
S. and Canada	301	13,041	7,660	742	5,495	3,573	653	145

achelor's enrollees and graduates for bachelor's-only programs were estimated on the basis of the ratio of responding programs to known programs. These estimates nclude only upper-division enrollees and graduates.

Admission Ratios. In lieu of acceptance ratios, this report discusses admission ratios—the ratio of the number of enrollees to the number of applicants in the academic year 1981-1982. Necessarily, only data from programs reporting both enrollees and applicants to a given degree program were used to obtain admission ratios. These ratios are reported for responding programs in Table 7. For master's-level programs, ratios are reported by ETB accreditation status of programs, as well as independently of ETB status.

These ratios varied from .54 to .72 across programs. Application of *t*-tests revealed that the overall ratios for master's-level programs (.65 and .63 for speech-language pathology and audiology programs, respectively) did not differ significantly (at the .05 level) from the ratio observed for doctoral-level programs, except for the lowest ratio of .54 for programs awarding the doctorate in speech-language pathology. The .65 and .54 ratios for master's and doctoral programs in speech-language pathology did differ significantly from one another. The admission ratios for ETB accredited programs were lower by .11 and .14 for master's programs in speech-language pathology and audiology, respectively, than for their nonaccredited counterparts. These differences, however, were found not to be statistically significant at the .05 level.

Faculty and Staff. Table 8 presents data on faculty, clinical staff, and faculty/student ratios in programs offering degrees at various academic levels. Data were analyzed across the various program levels to reflect any differences in staffing patterns between those programs offering only graduate degrees and those offering both graduate and undergraduate degrees. The table excludes programs offering only the bachelor's degree and those offering only the doctorate.

Staff were categorized as either faculty or nonteaching (clinical) supervisory staff, based on the premise that educational programs generally designate staff as having responsibilities that are primarily teaching or non-teaching. It should be recognized, however, that professional staff, or faculty, may also assume clinical supervisory responsibilities in some programs.

Table 8 reveals means of 8.2 and 2.6 full-time and part-time faculty, respectively, across all programs. Means of 1.8 full-time and 2.1 part-time clinical staff members were observed. Programs offering both master's and doctoral degrees reported a notably higher mean number of full-time faculty than programs offering only the master's or only bachelor's and master's degrees. Programs offering master's and doctoral degrees also reported a higher mean number of part-time faculty than any other type of program.

Table 7

Admission ratio for graduate educational programs by academic level, area of professional emphasis, and (for Master's programs) ASHA Education and Training Board (ETB) accreditation status

Educational Level and Emphasis	Number of Programs*	Admission Ratio**
Master's in Speech-Language Pathology, All	201	.65
ETB Accredited	117	.61
Non-ETB Accredited	84	.72
Master's in Audiology, All	126	.63
ETB Accredited	78	.57
Non-ETB Accredited	48	.71
Doctorate in Speech-Language Pathology	38	.54
Doctorate in Audiology	20	.68
Doctorate in Speech-Language-Hearing Science	15	.62

*Programs reporting both applicants and enrollees data.
**Ratio = enrollees/applicants.

Given the specified numbers of total enrollees in the various types of programs, faculty/student ratios were calculated in Table 8 by weighting the number of part-time faculty by .5 (effectively treating all part-time faculty as one-half time) and dividing the sum of full-time and weighted part-time faculty by the number of student enrollees. Ratios varied from 1:9.9 in programs offering degrees at all levels to 1:3.2 in programs offering only graduate degrees. The overall faculty/student ratio was 1 faculty member to every 8.9 students.

Conclusions

Perrin (1979) reported for the academic year 1978-79 that a total of 318 programs (including one in Puerto Rico) offered undergraduate and/or graduate degrees in speech-language pathology and audiology. By contrast, the present survey (excluding 3 Canadian programs, for comparison) determined that

Table 8

Selected faculty, staff, and student characteristics of graduate educational programs by academic level

Education Level of Programs	Number of Responding Programs	Number of Faculty				Number of Enrollees			Number of Clinical Staff			
		Full-time		Part-time					Full-time		Part-time	
		All Programs	Average Per Program	All Programs	Average Per Program	All Programs	Average Per Program	Faculty Student Ratio*	All Programs	Average Per Program	All Programs	Average Per Program
Master's	17	103	6.06	33	1.94	397	23.35	.30(1:3.3)	38	2.23	41	2.41
Bachelor's and Master's	152	1,100	7.24	339	2.23	11,822	77.78	.11(1:9.3)	162	1.07	267	1.76
Master's and Doctorate	7	76	10.86	53	7.57	332	47.43	.31(1:3.2)	31	4.43	12	1.71
Bachelor's, Master's and Doctorate	51	587	11.51	168	3.29	6,656	130.51	.10(1:9.9)	172	3.37	151	2.96
Total	227	1,866	8.22	593	2.61	19,207	84.61	.11(1:8.9)	403	1.77	471	2.07

*Ration = (Full-time faculty + Part-time faculty/2)/Total students enrolled.

[illegible] programs offer such degrees. Thus, it appears that a net total of 20 college/university programs have been discontinued since 1978-79. Comparison of our data with those of Perrin (1979) reveals that 11 of this net difference involved programs offering only undergraduate degrees.

Table 9 compares data from this survey with those of earlier efforts to reveal a historical view of the pattern of growth of educational programs in the profession. These data include bachelor's-only programs. The slowing of growth in the number of educational programs in the late 1970s has been followed by an actual decline, as mentioned above, between 1979 and 1982. This decline is only the second documented decline to occur in the history of the speech-language pathology and audiology profession, and suggests a definitive reversal in the pattern of growth in the profession's educational mission.

The numbers of enrollees and graduates at all academic levels are compared for the academic years 1978-79 through 1982-83 in Figure 1. Data from four different sources are reported here to obtain the fullest possible view of recent enrollment and graduation trends. In the figure, 1978-79 is taken as the base year, with all subsequent data relative to that academic year. The four sources of data were: (1) Perrin (1979), who reported enrollment and graduates data for 1978-79, (2) The Higher Education General Information Survey (HEGIS) of the National Center for Education Statistics, from which graduates data were available for 1978-79 through 1980-81, (3) the present study (covering enrollment and graduates data for 1981-82), and (4) data from the National Survey of the Council of Graduate Programs in Communication Sciences and Disorders (1983), from which we have estimated the number of graduates for the 1981-82 academic year and graduate and upper-division undergraduate enrollments for 1982-83, based on an overall 88% response rate. Data from programs in Puerto Rico and Canada are excluded in Figure 1 for comparability.

Table 9
Number of graduate and undergraduate programs in speech-language pathology and audiology in the U.S.

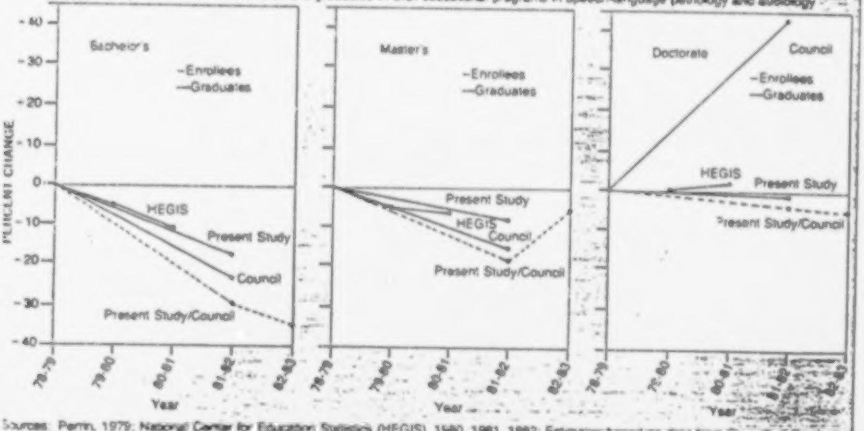
Year	Number of programs
1959-60	193
1961-62	199
1962-63	194
1965-66	247
1968-69	264*
1970-71	289
1972-73	294
1973-74	302
1978-79	318
1981-82	298

*Revised.
Sources: Perrin, 1979; U.S. Department of Health, Education, and Welfare, 1977; Willis and Willis, 1974; Willis and Willis, 1976.

Declines are evident for both enrollments and graduates at the undergraduate and master's levels over the three-year period between 1979 and 1982. Percentage differences for the HEGIS data corroborate the findings of other surveys for graduates at these academic levels. As compared to 1978-79, undergraduate enrollments declined by 36% through 1982-83, and the number of graduates of undergraduate programs declined by 19%-25% (depending upon data source) through 1981-82. At the master's level, graduates of the 1981-82 school year were down by 8.5%-15% when compared to 1978-79, reflecting a gradual decline in enrollments through 1981-82. Master's-level enrollments appear to have increased substantially during the 1982-83 school year, although this outcome could be an artifact of our estimates based on data of the Council of Graduate Programs.

Enrollments at the doctoral level appear to have remained relatively steady between 1979 and 1983, but the overall data suggest that a notable increase in the number of graduates may have occurred since 1979. Perrin's (1979) data revealed 147 doctoral degrees awarded in 1978-79; these awards were estimated from the data of the Council of Graduate Programs (1983) to

Figure 1
Percent change in numbers of enrollees and graduates in U.S. educational programs in speech-language pathology and audiology



Sources: Perrin, 1979; National Center for Education Statistics (HEGIS), 1980, 1981, 1982; Estimates based on data from Council of Graduate Programs in Communication Sciences and Disorders, 1983; present study.

number 209, an increase of 42%. Because the absolute numbers of doctoral enrollees and graduates were relatively small, and because our estimate based on such small numbers is particularly sensitive to bias, the 42% change probably overdramatizes any change that has occurred in doctoral graduates.

Although we cannot determine in the scope of this report the extent to which these overall declines are due to cutbacks in educational funding, conscious efforts to limit enrollments, a reduced appeal of the profession to young persons, or general economic malaise, the declines seem related to factors other than the reduction in the number of educational programs since 1978-79. We tested the speculation that the observed pattern is commensurate with a general pattern of decline in the numbers of students attending and graduating from educational programs in the U.S. Data from the U.S. Bureau of the Census (1982) indicate that full-time equivalent college-university undergraduate and graduate (combined) enrollment increased from 9.8 million in 1978 to 10.7 million in 1982, an increase of 9.2% (representing a 3.1% average annual increase). Relative to 1978-79, increases of 1.5% and 4.2% were observed by the Census Bureau in awarded undergraduate and doctoral degrees, respectively, in 1981-82. In contrast, a slight decrease in master's degrees awarded (4.7%) was noted, representing an average annual decline of 1.6%.

Thus, the declines in enrollees and graduates in speech-language-hearing programs between 1978-79 and 1981-82, most notable at the undergraduate level, seem to have occurred during a period of a mild upswing in the numbers of enrollees and graduates at the undergraduate and doctoral levels. The declines, however, in the number of master's graduates in speech, language, and hearing is consistent with a general downward trend observed in all master's programs in U.S. universities.

It is concluded, therefore, that the observed declines are only partially reflective of contemporary trends in higher education. They appear to represent overall the strengthening of a trend observed by Perrin (1979) toward declining enrollments in graduate and undergraduate programs in the profession. It is apparent that the course of the budgetary and legislative circumstances that fostered enhanced enrollments in speech-language-hearing educational programs in the 1960s and early 1970s has changed and is no longer leading to increases in the production of graduates in these programs.

Lingwall and Snope (1982), based on a survey sample of 54% of all directors of undergraduate and graduate educational programs, observed that applications to master's and doctoral programs were reported to have declined by an estimated 25% to 43%, respectively, over a five-year period between 1976-77 and 1981-82. About one-third of the responding program directors indicated declines in the overall quality of undergraduate and master's students, while slightly more than one-half of them reported declines in student quality at the doctoral level. The implication of such figures is that educational programs may be responding to current trends with efforts to boost faltering enrollments by acceptance of students with poorer academic credentials and professional promise.

A planned series of investigations by the Association is underway to obtain the kind of data necessary for developing long-range strategies with respect to the discipline's education needs. These studies will concentrate on assessment of the current and future demand for speech-language pathology and audiology services and personnel. Such an effort is critical if the profession is to prepare optimum numbers of adequately skilled personnel to meet the societal demand for services to the communicatively impaired.

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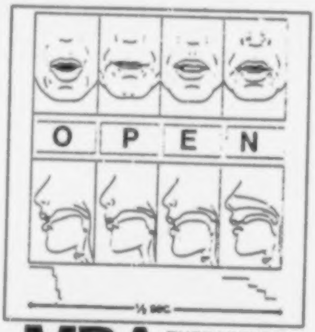

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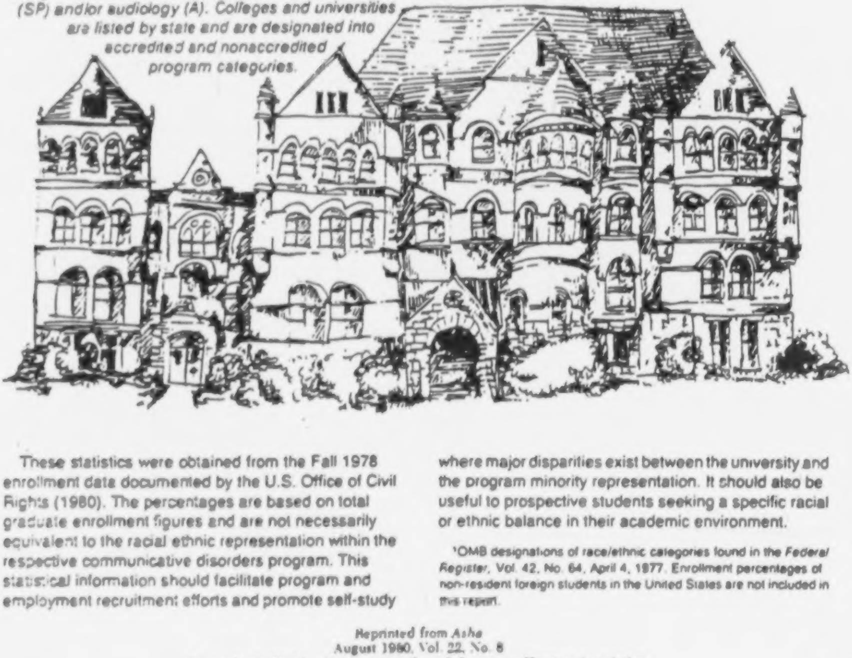
Racial and ethnic enrollment of training institutions with communicative disorders programs

Lorraine T. Cole

Approximately four percent of the ASHA membership represent racial/ethnic minority groups. Insight into the source of this manpower requires examination of the racial and ethnic make-up of institutions where training of professionals in communicative disorders occurs. This report was prepared by Lorraine T. Cole, Ph.D., ASHA's Director of the Urban and Ethnic Program. Cole delineates the percentages of American Indians or Alaskan Natives, Blacks (non-Hispanic), Asians or Pacific Islanders, and Hispanics[1] enrolled in colleges and universities with graduate programs in speech-language pathology (SP) and/or audiology (A). Colleges and universities are listed by state and are designated into accredited and nonaccredited program categories.



These statistics were obtained from the Fall 1978 enrollment data documented by the U.S. Office of Civil Rights (1980). The percentages are based on total graduate enrollment figures and are not necessarily equivalent to the racial ethnic representation within the respective communicative disorders program. This statistical information should facilitate program and employment recruitment efforts and promote self-study where major disparities exist between the university and the program minority representation. It should also be useful to prospective students seeking a specific racial or ethnic balance in their academic environment.

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[1] OMB designations of race/ethnic categories found in the *Federal Register*, Vol. 42, No. 64, April 4, 1977. Enrollment percentages of non-resident foreign students in the United States are not included in this report.

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Percentages of minority enrollment

Accredited programs	American Indian or Alaskan Native	Black (Non-Hispanic)	Asian or Pacific Islander	Hispanic	Total	Training Program
Alabama						
University of Alabama	.0	6.6	.1	.2	6.9	SP/A
Auburn University	.0	4.4	.4	.1	4.9	SP/A
Arizona						
University of Arizona	.6	.7	.9	2.9	5.2	SP/A
Arizona State University	.7	1.1	.9	2.7	5.5	SP/A
Arkansas						
University of Arkansas Little Rock	1.1	8.5	.2	.0	9.7	SP/A
California						
San Francisco State Univ.	.5	5.9	10.9	3.5	20.7	SP/A
California State University Fullerton	.8	1.8	4.5	5.7	12.7	SP/A
San Diego State University	1.1	2.0	3.4	6.4	12.9	SP/A
University of California Santa Barbara	.2	1.9	3.1	6.7	11.9	SP/A
University of the Pacific	2.0	11.8	10.6	24.6	68.1	SP
California State University Long Beach	.6	3.7	8.0	4.0	16.4	SP/A
San Jose State University	1.3	3.4	9.3	4.8	18.9	SP/A
California State University Sacramento	1.3	3.9	6.6	4.2	16.0	SP/A
California State University Northridge	2.4	2.3	6.7	5.6	16.9	SP/A
Colorado						
University of Colorado Boulder	.1	1.4	1.1	2.5	5.1	SP/A
Colorado State University	.3	1.3	.7	.8	3.1	SP/A
University of Denver	1.0	1.9	1.2	1.8	5.9	SP/A
Univ. of Northern Colorado	.3	2.7	1.2	3.4	7.6	SP/A
Connecticut						
University of Connecticut	1	1.8	.6	1.2	3.8	SP/A
Southern Connecticut State College	.0	1.3	.2	.5	2.0	SP/A
District of Columbia						
George Washington University	.3	7.9	2.7	1.6	12.5	SP/A
Gallaudet	0	4.0	.0	1.5	5.5	A
Florida						
University of Florida	.1	3.3	8	2.8	7.1	SP/A
Florida State University Tallahassee	.2	5.7	.3	1.6	7.8	SP/A
Georgia						
Emory University	.2	4.7	4	4	5.8	SP/A
University of Georgia	.3	4.0	.5	.3	5.1	SP/A
Idaho						
Idaho State University	.5	.7	1.8	5	3.5	SP/A
Illinois						
University of Illinois	.3	2.3	2.7	1.4	6.6	SP/A
Southern Illinois University	.3	5.3	.5	.2	6.3	SP/A
Western Illinois University	.2	2.4	.2	.9	3.7	SP/A
Northwestern University	.1	3.1	1.8	.8	5.8	SP/A
Bradley University	.4	8.0	.4	.0	8.7	SP
Illinois State University	.2	2.2	.6	.4	3.4	SP/A
Eastern Illinois University	.5	2.8	.3	.2	3.8	SP
Northern Illinois University	.2	2.4	.6	.5	3.7	SP/A
Indiana						
Indiana State University	.1	1.9	.4	.1	2.5	SP/A
Indiana University	.5	2.5	.7	1.0	4.7	SP/A
Purdue University	.1	1.2	.8	.5	2.6	SP/A
Ball State University	.2	3.9	.4	.4	5.0	SP/A
Iowa						
University of Iowa	.3	2.0	1.0	.5	3.8	SP/A
University of Northern Iowa	.1	2.5	4	.5	3.6	SP/A
Kansas						
University of Kansas	.4	2.4	.5	.9	4.3	SP/A
Kansas State University	.4	2.1	.2	.5	3.2	SP/A
Wichita State University	4	4.2	.9	1.5	6.9	SP/A
Louisiana						
Tulane University	.6	4.1	1.4	3.3	9.4	SP/A
Louisiana State University	.2	4.7	1	.9	5.9	SP/A
Louisiana State U Med. Ctr.	0	5.4	4.1	2.7	12.2	SP/A
Maryland						
University of Maryland	.3	5.8	1.2	1.0	8.2	SP/A
Massachusetts						
University of Massachusetts	.3	6.1	1.9	2.7	11.0	SP/A
Boston University	.1	2.3	1.1	1.1	4.6	SP/A
Michigan						
University of Michigan Ann Arbor	.3	7.1	1.8	1.3	10.5	SP/A
Michigan State University	.2	4.2	.9	.9	6.3	SP/A
Wayne State University and Wayne State University School of Medicine	9	15.2	2.4	.9	19.3	SP A
Central Michigan University	.1	.8	.2	.4	1.5	SP/A
Western Michigan University	.2	3.1	.5	1.0	4.8	SP/A
Northern Michigan University	.5	.1	.4	.5	1.4	SP
Eastern Michigan University	.1	6.1	.8	.4	7.4	SP

Accredited programs	American Indian or Alaskan Native	Black (Non-Hispanic)	Asian or Pacific Islander	Hispanic	Total	Training Program
Minnesota						
University of Minnesota Minneapolis-St. Paul	.3	1.2	1.3	.8	3.6	SP/A
University of Minnesota Duluth	.2	.2	.5	.2	1.1	SP
Mississippi						
Univ. of So. Mississippi	.1	9.7	.8	.1	10.6	SP/A
University of Mississippi University	.0	5.2	.7	.4	6.3	SP/A
Missouri						
University of Missouri	.2	2.1	3.3	.8	6.4	SP/A
Central Missouri State Univ.	.0	4.3	.1	.1	4.5	SP/A
Northeast Missouri State University	.3	.5	1.9	.3	3.0	SP
Central Institute for the Deaf, Washington University	.1	6.5	10.2	.9	17.7	SP/A
Montana						
University of Montana	1.0	.1	.7	.5	2.4	SP/A
Nebraska						
University of Nebraska	.2	1.1	.8	.8	3.0	SP/A
New Mexico						
University of New Mexico	2.3	1.6	1.0	15.2	20.1	SP/A
New York						
SUNY College of Arts and Sciences, Geneseo	0	.2	.0	.0	.2	SP/A
Syracuse University	.1	1.7	1.0	.6	3.3	SP/A
Brooklyn College of the City University of New York	.9	13.7	2.8	7.9	25.2	SP/A
Teachers College Columbia University	.3	13.1	4.1	4.5	21.9	SP/A
Adelphi University	.2	9.3	1.1	1.7	12.3	SP/A
Queens College of CUNY	.8	13.6	2.8	7.9	25.0	SP/A
Hunter College of CUNY	.8	13.6	2.5	7.5	24.4	SP/A
Hofstra University	.0	3.4	.7	2.4	6.5	SP/A
New York University	.3	5.0	3.5	2.8	11.7	SP/A
Ithaca College	.7	1.5	.0	.0	2.2	SP/A
SUNY at Buffalo	.2	2.6	.2	.3	3.4	SP/A
North Dakota						
University of North Dakota	1.2	.8	1.4	.3	3.7	SP
Minot State College	.0	0	.0	.0	.0	SP
Ohio						
Case Western Reserve Univ.	.1	2.3	.6	.2	3.1	SP/A
Kent State University	.2	3.9	.2	.2	4.5	SP/A
Ohio University	.3	2.9	.1	.2	3.4	SP/A
University of Cincinnati	.1	6.2	.9	.7	8.0	SP/A
Ohio State University	.2	4.9	.7	.5	6.3	SP/A
Cleveland State University	.1	9.9	1.3	.3	11.6	SP/A
University of Akron	1	4.0	.5	.4	5.1	SP/A
Bowling Green State Univ.	.1	3.6	1.2	.7	5.5	SP/A
Oklahoma						
University of Oklahoma	2.3	4.2	1.5	.8	8.8	SP/A
Phillips University	1.5	6.4	3.0	1.5	12.4	SP/A
Oklahoma State University	1.1	2.4	.9	.7	5.0	SP
Oregon						
Portland State University	.6	1.9	3.1	.5	6.1	SP/A
Pennsylvania						
Pennsylvania State University	.5	2.4	1.2	1.2	5.2	SP/A
University of Pittsburgh	.1	7.7	2.4	1.1	11.3	SP/A
Temple University	.4	7.0	1.6	1.0	10.0	SP/A
South Carolina						
University of South Carolina	.2	8.6	.4	.4	9.6	SP/A
South Dakota						
University of South Dakota	3.0	.1	.1	.1	3.4	SP/A
Tennessee						
University of Tennessee	.2	4.3	1.0	.5	6.1	SP/A
Vanderbilt University	.0	1.5	.4	.0	1.9	SP/A
Memphis State University	.0	13.9	.2	.1	14.2	SP/A
Texas						
University of Houston	.3	4.4	1.0	3.7	9.5	SP
Our Lady of the Lake College	.2	7.1	.2	37.9	45.3	SP
Southwest Texas State Univ.	1.4	2.5	.7	5.9	10.5	SP
University of Texas, Austin	.2	1.6	1.0	4.6	7.4	SP/A
Southern Methodist University	.2	2.1	1.3	2.5	6.1	SP/A
North Texas State University	.4	4.9	4	1.9	7.6	SP/A
Utah						
University of Utah	.9	.7	1.9	1.5	5.1	SP/A
Brigham Young University	.4	.0	.8	.3	1.5	SP/A
Vermont						
University of Vermont	.2	.2	0	.0	.5	SP
Virginia						
University of Virginia	1	2.0	.4	.1	2.6	SP/A
Washington						
University of Washington	.6	2.0	3.8	.9	7.4	SP/A
Washington State University	.8	1.8	1.6	1.5	5.7	SP/A
West Virginia						
West Virginia University	.2	1.0	.1	.1	1.4	SP/A
Wisconsin						
University of Wisconsin Madison	.2	2.0	2.1	1.1	5.4	SP/A
University of Wisconsin Milwaukee	.5	4.8	1.5	1.8	8.6	SP
University of Wisconsin Stevens Point	1.0	.7	.7	.0	2.4	SP/A
Marquette University	.2	1.4	.5	4	2.4	SP
University of Wisconsin Eau Claire	.3	1.3	.7	.9	2.3	SP
Wyoming						
University of Wyoming	.3	4	.5	.8	1.9	SP/A

Nonaccredited programs	American Indian or Alaskan Native	Black (Non-Hispanic)	Asian or Pacific Islander	Hispanic	Total	Training Program
Alabama						
University of South Alabama	.0	9.3	.3	.1	9.7	SP/A
University of Montevallo	.0	12.8	.0	.0	12.8	SP/A
Arkansas						
Univ. of Central Arkansas	.0	6.9	.0	.0	6.9	SP
University of Arkansas	.9	7.1	1.0	.5	9.5	SP
Arkansas State University	.6	9.1	.3	.5	10.5	SP
California						
Humboldt State University	2.0	.4	1.4	.4	4.2	SP/A
California State University Chico	1.4	1.6	1.7	2.6	7.2	SP
California State University Fresno	1.2	2.8	4.0	5.3	13.3	SP/A
University of LaVerne	.3	6.4	.8	7.6	15.1	SP
California State University Los Angeles	.9	12.5	13.7	9.6	36.6	SP/A
Chapman College	1.4	1.5	2.4	1.7	7.0	SP
University of Redlands	.2	9.6	3.8	2.4	16.0	SP
Loma Linda University	.2	6.2	4.9	4.4	15.8	SP
University of San Francisco	.5	10.4	14.9	9.2	35.0	SP
California State College Stanislaus	1.1	2.9	2.4	4.7	11.0	SP
Whittier College	.0	1.5	6.1	10.6	18.2	SP
Colorado						
Adams State College	.0	.9	.0	27.9	28.8	SP
District of Columbia						
University of the District of Columbia (Federal City College)	1.2	86.1	3.3	.6	91.1	SP
Howard University	.1	62.5	1.4	.3	64.2	SP
Florida						
University of Miami	.4	5.4	2.7	9.2	17.6	SP/A
University of South Florida	.1	2.4	.2	1.2	3.9	SP/A
Georgia						
Georgia State University	.2	13.6	.9	.1	14.8	SP
Hawaii						
University of Hawaii, Manoa	.1	.6	40.0	1.5	42.3	SP/A
Illinois						
Southern Illinois University Edwardsville	.1	9.8	.4	4	10.6	SP/A
Governors State University	.2	31.6	1.6	3.9	37.3	SP
Kansas						
Fort Hays State University	.1	.2	.2	.3	.8	SP
Kentucky						
Western Kentucky University	.0	4.2	.0	.1	4.4	SP
University of Kentucky	3.1	1.8	.5	7	6.1	SP
University of Louisville School of Medicine	.2	5.7	1.9	.6	8.5	A
Murray State University	.3	4.1	.2	.3	4.9	SP/A
Eastern Kentucky University	.1	2.1	.0	.0	2.3	SP/A
Louisiana						
University of Southwestern Louisiana	.0	7.5	.1	.4	8.0	SP/A
Northwestern State University of Louisiana	.2	13.9	.0	4.4	18.5	SP
Louisiana Tech University	.4	12.9	.1	.0	13.4	SP/A
Maine						
University of Maine, Orono	.1	.3	.2	.4	1.0	SP
Maryland						
Loyola College	.4	4.5	.5	3	5.8	SP
Towson State University	.2	8.6	.3	.3	9.4	SP/A
Massachusetts						
Emerson College	.8	5.0	.8	2.5	9.1	SP
Northeastern University	.3	3.2	5.3	1.4	10.2	SP/A
Worcester State University	.0	.6	1.2	.1	1.9	SP/A
Minnesota						
Mankato State University	.1	.2	.0	.0	.3	SP
Moorhead State University	.0	1.1	.0	.0	1.1	SP
St. Cloud State University	.0	.0	.0	.0	.0	SP
Mississippi University for Women	.0	22.8	.0	.0	22.8	SP
Missouri						
Southeast Missouri State University	.1	2.4	.4	.3	3.2	SP
Northwest Missouri State University	.3	.1	.1	.0	.6	SP
Fontbonne College	.0	9.7	3.2	.0	12.9	SP
St. Louis University	.2	8.2	1.7	.5	10.6	SP/A
Nebraska						
Kearney State College	.2	.2	.0	.6	.9	SP
University of Nebraska	.0	4.1	.6	.7	5.4	SP
Nevada						
University of Nevada	.5	.7	1.7	1.1	4.0	SP/A
New Jersey						
Douglass College	.1	6.3	2.1	1.8	10.3	SP
Seton Hall University	.0	5.3	2.2	2.0	9.6	SP/A
Trenton State College	.1	6.5	.3	.6	7.5	SP/A
Kean College	.1	8.5	.3	1.4	10.3	SP/A
Montclair State College	.0	1.8	.6	1.9	4.2	SP/A
William Paterson College	.0	3.1	.2	1.8	5.2	SP/A
New Mexico						
New Mexico State University	.9	.7	.5	12.9	15.0	SP/A
Eastern New Mexico University	1.7	2.8	.4	5.1	10.0	SP

Nonaccredited programs	American Indian or Alaskan Native	Black (Non-Hispanic)	Asian or Pacific Islander	Hispanic	Total	Training Program
New York						
College of St. Rose	.0	.9	.0	.2	1.1	SP
Lehman College	.7	14.4	2.4	8.4	25.9	SP
State University College Buffalo	.4	4.3	1.4	.9	6.9	SP
SUNY College, Fredonia	1.0	1.3	.0	1.0	3.2	SP/A
C. W. Post College	.1	2.1	1.3	1.5	4.9	SP/A
City College of CUNY	.8	11.1	4.5	5.8	22.2	SP/A
SUNY College, Plattsburgh	2.3	2.3	1.2	.0	5.8	SP/A
Nazareth College of Rochester	.0	2.4	.2	1.0	3.6	SP
North Carolina						
Appalachian State University	.2	4.7	.2	.3	5.5	SP
University of North Carolina Chapel Hill	.4	6.3	1.0	.9	8.6	SP/A
Western Carolina University	.4	4.2	.4	.0	5.0	SP
North Carolina Central Univ.	.0	77.4	.0	.0	77.4	SP
University of North Carolina Greensboro	.1	6.6	.3	.3	7.3	SP/A
East Carolina University	.4	13.8	.2	.1	14.4	SP/A
Ohio						
Miami University	.0	3.7	.3	.8	4.8	SP
Oklahoma						
Central State University	1.1	6.7	.3	.5	8.6	SP
Northeastern Oklahoma State University	12.9	6.9	.3	.2	20.3	SP
University of Tulsa	.6	1.9	.3	.2	3.0	SP/A
Oregon						
Oregon State University	1.2	.8	1.4	.5	3.9	A
University of Oregon	.5	.8	1.4	1.0	3.7	SP
Oregon College of Education	1.5	.0	2.2	.0	3.6	SP/A
Pennsylvania						
Bloomsburg State College	.0	.0	.0	.0	.0	SP/A
California State College of Pennsylvania	.0	4.1	.9	.2	5.2	SP
Clarion State College	.0	1.2	.0	.0	1.2	SP
Edinboro State College	.1	1.2	.3	.3	1.9	SP
Indiana University of Pennsylvania	.0	.6	.0	.0	.6	SP
Hahnemann Medical College and Hospital	.0	4.9	.0	.4	5.3	SP/A
West Chester State College	.0	4.4	.2	.4	5.0	SP
Rhode Island						
University of Rhode Island	.2	1.0	1.3	.3	2.9	SP/A
South Carolina						
South Carolina State College	.0	83.8	.0	.0	83.8	SP
Winthrop College	.2	8.4	.0	.2	8.8	SP
Tennessee						
East Tennessee State Univ.	.1	2.4	2.0	.6	5.1	SP/A
Tennessee State University	.1	43.4	.1	.0	43.6	SP/A
Texas						
Abilene Christian University	.5	9.5	.5	1.7	12.2	SP
Lamar University	.5	4.0	.7	2.8	8.1	SP
East Texas State University	.7	8.8	.2	3.5	13.2	SP
University of Texas, Dallas	.3	2.0	.4	1.8	4.5	SP/A
Texas Woman's University	.3	9.2	3.0	3.8	16.3	SP/A
University of Texas, El Paso	.1	1.5	.6	26.7	28.9	SP/A
Texas Christian University	.5	2.2	.7	1.7	5.2	SP
University of Texas Health Science Center, Houston	.4	5.1	1.1	3.5	10.1	SP
Texas Tech University	.7	.4	3.2	1.8	6.1	SP/A
Stephen F. Austin University	.2	5.3	.8	2.4	8.7	SP
Baylor University	.4	1.2	1.3	.6	3.5	SP/A
Utah						
Utah State University	.0	.5	.7	.3	1.4	SP/A
Virginia						
Hampton Institute	.0	80.6	2.4	1.0	84.0	SP
James Madison University	.2	2.8	.0	.3	3.2	SP/A
Old Dominion University	.0	7.7	1.9	.5	10.1	SP
Radford College	.1	1.4	.0	.0	1.5	SP/A
Washington						
Western Washington University	.5	.8	1.1	.5	2.7	SP/A
Eastern Washington University	1.0	1.7	.7	1.7	5.1	SP
Central Washington State University	.4	.8	1.2	.8	3.1	SP
West Virginia						
Marshall University	1.0	2.2	2.0	.2	5.4	SP
Wisconsin						
University of Wisconsin Oshkosh	.3	1.1	.2	.4	2.1	SP/A
University of Wisconsin River Falls	.0	1.6	.3	.5	2.4	SP
University of Wisconsin Whitewater	.1	1.5	.4	.9	2.9	SP
Puerto Rico						
University of Puerto Rico Medical Sciences	.0	.0	.0	100.0	100.0	SP/A

aamc association of american medical colleges

Statement of the Association of American Medical Colleges

on

"The Health Professions Training Assistance Act of 1984."

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to share with the Committee its views on "The Health Professions Training Assistance Act of 1984." Since its founding in 1876, the AAMC has steadily expanded its horizons so that today it represents the whole complex of individual organizations and institutions charged with the undergraduate and graduate education of physicians. It serves as the national voice for the 127 U.S. accredited medical schools and their students; more than 400 of the major teaching hospitals; and over 70 academic and professional societies whose members are engaged on an everyday basis in the activities--teaching, research and patient care--that in the aggregate constitute medical education.

The AAMC is commenting on this important legislation with some reservation, since there are substantial risks in taking a position on only a summary of the proposed legislation, and not the legislation itself, which is still in the process of being

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Submitted to the Senate Committee on Labor and Human Resources, March 29, 1984.

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drafted. There undoubtedly will be many nuances in the legislation as introduced that cannot possibly be reflected in the summary available to the AAMC as it prepared this statement. However, given the large and beneficial impact which the Title VII programs have on medical education, the AAMC feels compelled to make known its views on this important subject, even in less than optimal circumstances.

The Association has two very general responses to the bill as presented by Chairman Hatch. The first is gratitude for its reaffirmation of support for virtually the entire array of currently authorized programs in Title VII. As will be delineated below, these programs have extremely positive effects on many facets of medical education. Some of these effects include: permitting students from many different socio-economic strata of society to enter medical school; sustaining high quality in specific medical educational programs that the government wishes to augment; and influencing the specialties and practice locations that individual physicians choose for their careers. The clear message of the proposed reauthorization of the Title VII programs is that they are both useful and efficient in meeting their purposes. The medical schools do not take the partnership they have entered into with the federal government for granted and they heartily commend Senator Hatch's approach.

The Association is troubled by the statement in the summary that the programs will be authorized at "levels consistent with

FY '84 Appropriations." Many of the '84 appropriations levels are below the austere authorization levels imposed on them through the 1981 Budget Reconciliation Process, but some of them are pushing their authorization ceilings. There seems to be no good reason to foreclose the possibility of bolstering funding for the manpower programs should greater congressional support for them arise or should the prevailing economic climate improve. The Association is especially concerned about the application of the bill's authorization level policy to the student financial assistance programs. These programs are seriously underfunded at present and, in the case of the HPSL program, not funded at all. We hope that the bill will reflect the need for more support of the EFN and HPSL programs, as well as a higher credit limit for the HEAL program, when it is marked up.

JUSTIFICATION OF FEDERAL ROLE IN MEDICAL EDUCATION

Prior to outlining its specific program recommendations, the AAMC believes it is necessary to outline its views on the support of medical education.

In reviewing recent developments, the AAMC has been impressed with the need for, and justifiability of, marshalling support for medical education from all of its beneficiaries: students, institutions, and the public. With medical school tuition costs steadily increasing--currently exceeding, for example,

$12,000 annum per student at private institutions, exclusive of living expenses--the option of financing medical education on one's own simply is not available for the vast majority of students wishing to attend medical school. Thus, Federal aid is an absolute necessity, if interested students are to be able to finance their education. This point needs to be taken into account outside of any other considerations--minority participation in medical education, manpower distribution and specialty choices, and desirable advances in curriculum--because it is in the interest of our society to assure that students who are capable of becoming doctors can make the financial arrangements to do so.

From an institutional perspective, the medical schools, believe Federal support is justified by the fact that their activities are essential to meeting national goals which the government has set, and that without federal participation, these goals can not be met. With health care costs reaching 10.5% of the GNP in 1982, the relatively small investment the federal government makes in the Title VII programs can have important impacts on how, and which, health care services are delivered. For example, medical schools have emphasized primary care specialties at the behest of the Federal government, with demonstrable results, and thus merit and require continued Federal support in these areas. In other areas as well, it behooves the federal government to provide targeted forms of support to medical education, since this is a key link in the chain of activities which sustain the health of the American population, an area in which the government has a clear and abiding interest.

SPECIFIC PROGRAM RECOMMENDATIONS

Student Assistance

Rationale for AAMC Position

Prior to addressing the specifics of the student aid proposals advanced by the reauthorization proposal, it is necessary to outline the basic rationale upon which the Association's views on the proper role of student aid in medical education is predicated:

- In view of their future high income potentials, all but the most impoverished students and their families should ultimately bear primary responsibility for financing the cost of medical education through direct payment, loan repayment or service payback.

- The cost of obtaining a medical education is becoming almost prohibitive for the average individual. Tuitions have increased dramatically over the past decade. In private schools, the average first-year tuition was $11,863 in 1983-84. The median first year tuition for in-state residents in public schools is now $2,723, and $7,000 for non-residents. Without a reasonably comprehensive set of aid programs, the opportunity to secure an M.D. degree will be limited to only those fortunate enough to occupy the upper economic levels of our society--those who are more accustomed to the notion of investing large sums for a future return.

- The period of training required to become an adequately educated physician is long and arduous, usually encompassing a post-baccalaureate span of no less than 7 and often several more years.

- The medical school curriculm and the structure of the medical education program is so rigorous and demanding that it makes outside employment to defray expenses virtually impossible for most students. The negligable reliance of medical students on the College Work Study Program, which comprises less than 1% of aid awarded to medical students, illustrates this.

- Medical students who finance their education through borrowing are faced with the prospects of high and rapidly rising debts. The average debt of students with indebtedness who graduated in 1983 was $23,914. A recent study completed by the Educational Testing Service demonstrated that this debt load is unacceptably high for new M.D.s if special repayment accomodations are not made.

Criteria for student aid

The AAMC has long held that, to the extent possible, medical students, with contributions from their families, should pay for their own education, whether out of pocket or by borrowing. On the other hand, many medical schools have adopted, and most would like to adopt, a "needs blind" admission policy, i.e., to accept the most promising applicants, irrespective of their ability to pay. Since a major Federal objective has also been to expand educational opportunity for the economically disadvantaged, the goals of academic institutions and the government are, fortuitously, completely congruent. It is thus in the interest of the entire society that the Congress enact into law an appropriately balanced portfolio of programs designed to meet the needs of all qualified students seeking access to a medical education, regardless of their economic status. Such a structure should encompass: scholarships for the most impoverished students; subsidized loans for students with substantial need; and market rate loans for the financially able.

The characteristics to be built into these programs obviously merit careful attention. Perhaps the most important is the assurance of availability of assistance. Once students have gained acceptance into medical school, they should be able to pursue their education with reasonable certainty that assistance will be available until graduation. This has not been the case for the past 3 years, as the Title VII student assistance programs and other related student aid programs have been subject to a series of legislative and administrative contigencies. Several additional characteristics, however, are intrinsic to a well designed and cost effective assistance structure. The Association maintains that future student aid programs should reflect the lessons of past experience and thus should:

- Establish repayment options to accommodate the burgeoning debt loads of students, recognizing the economic reality that initiation of repayment of loans is virtually impossible during undergraduate medical education, oftentimes extremely difficult during graduate medical education, and frequently a serious hardship during the very early years of practice, when net incomes may not be especially handsome.

- Award the largest share of assistance strictly on the basis of need, at the discretion of the financial aid officer at each medical school. It is imperative, particularly during the current economic climate, that the limited resources available to aid students be distributed in the most cost-effective manner. Given the diversity of individual needs and circumstances and the complexities of the various aid programs, the school financial aid officer is the most qualified and best positioned individual to make these determinations.

- Expand opportunities for students to repay their indebtedness through loan forgiveness. In academic year 1982-1983, as was mentioned, 86% of all graduating medical students reported indebtedness. Moreover, the percentage of graduating students with debts above $30,000 increased from 10% in 1980 to 13.5% in 1983. The Association believes that service as a means of repayment will become an increasingly more attractive and even a necessary alternative to many students as their level of indebtedness increases. Thus, loan forgiveness becomes a viable option. Compared to using scholarships, loan repayment programs are more advantageous to the Federal Government in that the latter need only invest in exactly the numbers and types of personnel it needs when it uses them for specific assignments, rather than trying to estimate public service needs 5 to 7 years before they actually must be met. This mechanism has the added advantage of not forcing students to make premature career choices of specialty. Its usefulness is, however, contingent upon government requirements for physicians.

The Association must weigh student aid proposals in light of their potential to meet these important criteria.

Exceptional Financial Need (EFN) scholarships are a form of assistance to enable students with severely limited resources to finance the first year of their medical education. The rationale for the program has been based on the experience that economically underprivileged students, however talented, are almost uniformly unwilling to incur indebtedness when they are uncertain about their ability to survive the rigors of the educational program. The EFN scholarship allows students a financially risk free first year, after which successful students--the overwhelming majority--are willing to negotiate loans for their subsequent educational expenses. In addition, many of these students then agree to commit themselves to the National Health Service Corps and are able to secure NHSC scholarships to complete their education. Given the impediments to matriculating severely needy students into medical school, the AAMC believes that the EFN program should be reauthorized at levels sufficient to allow 5 students at each medical school to be supported with EFN Scholarships. We estimate this would cost $8 million the first year. Thus, we again recommend that you authorize this program at a significantly higher level than the $5.6 million FY '84 appropriation for all health professions students.

The Health Professions Student Loan (HPSL) program was established as a government capitalized, needs-based, campus-administered, low cost loan to medical and other students for education in the health professions. Federal funds, matched by educational institutions at a ratio of 9:1, are made available on a recallable basis to medical schools, where they are loaned, in amounts proportional to need, to students at subsidized interest rates specified in statute. Repayment of principal and accrued interest can be deferred until one year after graduation--and up to a 3-year period for physicians engaged in residency training and specified public service activities--and must be completed in 10 years, excluding these periods. Reimbursements flow into the student loan fund in the school from which the student borrowed, and immediately become avalable for relending to new borrowers.

This program has been extremely helpful in expanding educational opportunity for needy students, and should certainly be retained. However, several problems should be noted. The revolving funds in the schools have received little new capitalization in recent years; this is a particularly acute problem for new schools who have come "on line" in the recent era of low funding and have low revolving fund levels. The recent reluctance of the Appropriations committees to provide further capital for the HPSL program has coincided with widely-publicized hearings concerning high default rates in the program, as well as Administration Budget requests alloting no funds for increasing the revolving funds in either FYs '83 or '84. The same request has been made for the upcoming fiscal year. These actions belie the fact that greatly increased funds are needed for the program, a situation due more to rising tuitions and impending increases in the HEAL interest rate than poor institutional administration of the program.

The HPSL program serves the very significant portion of the medical student population that does not have the resources to contemplate substantial reliance on the HEAL program; even with current funding constraints, 9,551 medical students qualified for and were awarded HPSL loans in 1982-83, for an average award of $2,403. A boost in funding would allow this average to increase somewhat with increases in tuition. Given markedly improved collection performances by the participating medical institutions--the percentage of delinquent borrowers dropped from 11.34% in 1980-81 to 7.83% in 1982-83--as well as the clear need for program funding increases, the Association recommends that the program be authorized at a level of $20 million for FYs '85-'89. This figure, though substantially higher than recent appropriations, would signal to appropriations committees that the HPSL program remains a viable and valuable one, and that its funding levels should reflect its importance.

The Association strongly opposes the proposal to limit new HPSL capital contributions to schools which established loan funds after July 1, 1972. The adoption of this approach now could mark an end to continuing capital contributions to the long-participating institutions; such a policy which would ultimately erode this extremely important program altogether. While some of the new schools are indeed in dire need of fresh capital, some of the schools which have been in the program for a long time need it almost as badly. We urge you to reconsider this decision and to give the schools and their students a vote of confidence for improved collection rates.

The Association is also recommending that a separate line-item be created for HHS payment of HPSL loans for service in manpower shortage areas as described in Sec. 741(f) of the HPEAA, at ceilings of $8, $9, $10, $11, and $12 million over the next five years. Despite very strong statutory language directing the Secretary to make these payments, relatively few have been provided for a number of years. This has partly been due to the magnitude of the NHSC Scholarship program. In light of very heavy costs attached to providing NHSC Scholarships in return for service commitments in Sec. 332 areas, as well as the desirability of providing maximal flexibility for medical school graduates in choosing their careers, and finally, the heavy debt burdens accrued by most graduating M.D.s, the AAMC believes that implementation of the 741(f) authority is highly desirable both from the student and NHSC perspective. As funding for NHSC Scholarships is slashed drastically this alternative mechanism for attracting physicians to underserved localities is critical. Furthermore, the current statutory formula is well designed to keep Federal costs under this provision from reaching excessive proportions.

Recent revelations that a substantial number of physicians who received HPSL awards are in arrears in repayment has besmirched the program in the eyes of the Congress and the public, but the prompt and effective response of the schools to reduce delinquency has gone a long way to restoring confidence in it. While the AAMC in no way condones the inefficient, less than aggressive loan collection procedures formerly prevailing in many of its schools, it also feels it only fair to note that a degree of this delinquency has been exaggerated by HRSA's peculiar definitions of delinquency. HRSA is currently reviewing its definition in light of very legitimate questions voiced by the health education professions community. Furthermore, it should be recalled that it is only a small portion of the participating schools which have displayed the extremely high default rates that have stigmatized the program, and that they too have made great strides in improving their program administration. For example, HRSA figures indicate that only 6 medical schools of 114 reporting had delinquency rates of over 15%, based on the better of the borrower or dollar calculations, as of June 30, 1983.

The Association also recommends that the Administration's proposal to allow schools to assess a penalty charge not to exceed 6 percent per year on that portion of a debt more than 90 days overdue be adopted. This change would parallel the Debt Collection Act of 1982. It appears that your legislation will include a similar initiative, which we commend.

The Health Educational Assistance Loan (HEAL) program provides a Federal guarantee for private sector loans to medical students. It operates by means of a loan insurance fund, from which lenders are reimbursed in the case of non-payment due to default, death or disability. Students may acquire loans from private lenders of up to $20,000 per year to an aggregate amount of $80,000. The allowable interest rate for these loans is 3.5%

above market rates (91-day Treasury bills). The statute sets limits on the amount of borrowing that the government will insure. In recent years, attempts have been made to reduce borrowing below these ceilings by applying limits on the Federal Credit Budget.

The HEAL program, created by P.L. 94-494, was not used extensively for several years. Recently, however, as costs of education have risen and as the more inexpensive assistance programs have become less available, both relatively and absolutely, medical student borrowing under this program has escalated sharply.

In 1982-83, HEAL medical student borrowing increased more than 50%, to $50.4 million total; the average loan was $7,695. Given this upward trend in borrowing, and similar trends in the borrowing of other health professions students, the Association strongly opposes the Administration's attempts to limit access to the HEAL Program through ceilings on the credit budget or limitations in appropriations acts, particularly since the program requires no Federal outlays. The HEAL program serves adequately as a truly last resort source of loan capital for students, and is functioning fairly well, now that bank participation has been bolstered. The AAMC thus recommends that the HEAL program be authorized at a level of $275 million in FY 1985, with increases of $25 million in each of the succeeding fiscal years through FY 1989.

The Association was disappointed that your legislation will reflect a $250 million cap on this program. The HEAL program does not add to federal outlays and in its present structure can hardly be said to have a malevolent effect on the general allocation of credit in this country. Overall usage of the HEAL program has escalated at an extremely swift rate the last 3 years and it would be unsound public policy to limit access to it at an apparently arbitrary level. The $250 million cap could have an especially deleterious effect on health professions students because, if it were to take effect, there would be no mechanism for allocating the credit to those who most need it: a first-come, first-served policy would be in effect. Such a policy would be extremely undesirable for a loan-of-last-resort program. The Association also recommends that the statutory provisions to consolidate HEAL loans be retained in the expectation that the basic authority for this process in Sec. 439(o) of Title IV of the Higher Education will be renewed. The consolidation authority makes HEAL loan repayment simpler, though not less expensive, for many HEAL borrowers. The Association also agrees with the provision in your legislation that would give the Student Loan Marketing Association the authority to originate HEAL loans.

Administration Proposal - The Administration has proposed a new loan program for Disadvantaged/Exceptionally Financially Needy Students. The need for students of this category is very large and every possible contribution to meeting it is welcome. However, the Association would support it only if it is in addition to, and not instead of, the programs currently authorized in statute and discussed earlier in this statement.

Institutional Assistance

In the 10-15 years after enactment of P.L. 88-129, Federal programs emphasized assistance to the institutions responsible for educating students to become physicians. The last remaining authority of that category is in Sections 720 thru 726, for the construction of health teaching facilities.

Health Education Facilities Construction provisions in the statute (Part B, Sections 720-726) authorize grants and loan guarantees with interest subsidies for the construction of teaching facilities for health professional schools. Under this authority, the Federal government, especially through matching grants, participated to a very substantial degree in the building of new and the expansion and remodeling of existing facilities for medical education throughout the country. Funds totaling about $807 million were awarded to new and existing medical schools and affiliated teaching hospitals to assure an enrollment increase of 4,880, to maintain current enrollments of 7,711, and to expand the number of teaching beds by 5,563.

While the health education facilities program has not been funded since FY 1978, the reality is that many of the facilities built in the early days of the program are reaching an age when remodeling, renovating and reequipping, with their requirements for capital investment, will be necessary and for which matching

Federal assistance is justifiable. Recent surveys of the nation's research and teaching facilities by the Association of American Universities and the National Commission on Student Financial Assistance have pointed to the advanced state of deterioration of many of these facilities. The Department of Defense is also spearheading a multiagency effort to evaluate the university research infrastructure. While there may not currently be widespread Congressional enthusiasm for funding decaying facilities, it would be extemely unwise to preclude the opportunity to do so in the future. The Association thus recommends that the expired authority in Section 720(a)(3) be renewed for 5 years at a level of $5 million, and that the authorization in Section 726(e) for loan guarantees and interest subsidies be renewed at a level of $10 million for 5 years.

The Association was extremely encouraged to see that you have added grants for equipment and instrumentation to the authorities for construction of teaching facilities. There is a crying need for this support; hopefully your initiative will add impetus for funding of the other authorities in the facilities area as well.

Targeted Educational Initiatives

Over the more than two decades during which health manpower legislation has existed, its focus and emphasis has changed as events have unfolded. The AAMC has selected for discussion those issues that in its view are of the most importance today.

Primary Care Education - Federal financial assistance to schools of medicine has been absolutely critical to the effort to reverse a long undesirable trend toward too much subspecialization. Federal aid has made more attractive the development of, and training in, programs in primary care--family medicine, general internal medicine and general pediatrics--with which the schools have been able to launch many more students on careers as generalists. Partly a result of the initiatives taken by the Federal government in these areas, the number of health manpower shortage areas is predicted by the National Center for Policy Analysis to decrease by slightly more than 50% in the next 10 years. Thus, the partnership between the federal government and the nation's medical schools has clearly stengthened the nation's health care delivery system by ameliorating inadequacies in geographic and specialty distribution of physicians. The Family Medicine Residency and Training programs, for example, are widely thought to be responsible for the substantial increase over the last decade in the number of first year residents in family medicine--from 500 in 1972 to 2,628 in 1983. Since implementation of the program for graduate training of residents in general internal medicine and general pediatrics in FY 1977, the number of residents trained rose from 742 (412 general internal medicine and 330 general pediatrics) to 1,653 (833 general medicine and 820 general pediatrics) in FY 1981. This result in an increase in the number of primary care physicians and a concomitant increase in access to primary care educational opportunities for

1,653 intern/residents. In FY 1983, it is estimated that approximately 1,172 residents are in supportd programs. In FY 1982, 44.7 percent of all residents were in primary care specialties, a substantial increase of approximately 21 percent from 1970.

The important national goal of these efforts requires that these primary care educational programs be sustained, with Federal assistance an indispensible ingredient. Therefore, the AAMC recommends that: the authority for establishing and maintaining Departments of Family Medicine (Section 780) be extended at a ceiling of $15 million for each year from FY 1985 to FY 1989; authority for supporting residency training programs in Family Medicine (Section 786) be extended at a ceiling of $40 million for each year from FY 1985 to FY 1989; and authority for grants for training, traineeships and fellowships in general internal medicine and general pediatrics (Section 784) be extended at ceilings of $20 million for each year from FY 1985 to FY 1989.

Among the many narrowly targeted authorities in Title VII two warrant special attention at this time.

Computer technology - Section 769A authorizes grants for research and development on computer technology as it relates to medical service. Computer technology has evolved with astonishing speed in the last decade and is already making important contributions to medical service and education. But this technology still holds enormous potential for facilitating the handling of the huge volumes of scientific information that individual medical students and physicians must manage. Furthermore, the academic medical center is made functionally smaller by the immediate distribution of information through computers. Small investments in educational research in this domain will almost inevitably yield very large returns. Two recent Association publications (enclosed),--"Academic Information in the Academic Health Sciences Center" and "The Management of Information in Academic Medicine"--highlight the promise of this technology. The Association recommends that the expired authority for grants for computer technology health care demonstration programs as described in Sec. 769A be renewed with an annual funding ceiling of $15 million set for the period FYs 1985-'89. Funding for this provision ceased at the end of FY 1977 and none is included in your legislation. However, we urge that funding ceilings for the authority be reestablished so that important work in this area, now funded erratically and undependably through other sources, can continue to take place.

Geriatric Education - Section 788(d) authorizes grants to expand and improve education in geriatrics. Achievements of medical research have significantly extended life-spans and, when coupled with other phenomena, including sharp reductions in birth rates, resulted in a sharp expansion in the fraction of elderly in our society. The demographic realities of the present and future are forcing medical educators to intensify their focus on gerontology and geriatric medicine. The Federal government's concern in this area is obvious, since under its Medicare program it bears the major share of responsibility for funding the care of the elderly. From a host of societal perspectives, Federal investments in programs that could be implemented under this Section would be highly productive.

The field of gerontology is still in its nascent stages; its research agenda, which will be key to the development of this field, is still in the process of being defined. The proper clinical role for the gerontologist also needs further articulation. The development of both curricula and able teachers and researchers is critical to attracting medical students into this field. The Association thus recommends that the authority for projects to expand or establish educational programs in geriatric medicine is Sec. 788(d)(1) be extended for 5 years at a level of $25 million per year.

Area Health Education Centers - The AHEC program has been very effective in achieving the goal of decentralizing the conduct of health professions education by funding portions of such training programs in educational sites organized with AHEC funds in shortage areas. Essentially, AHECs comprise a regionalized systems approach to the development of health personnel; each project embodies multiple centers at various stages of development. Current law, P.L. 97-35, requires that 10% of each participating medical school's undergraduate eeducational program take place in an AHEC, and that the grantee institution share with the Federal government in the support of the activity to the minimum extent of 25% of the project cost.

Many medical schools have come up with extremely original configurations that have given their students training and exposure they would never have received otherwise. The AAMC recommends that this program be authorized at $25 million in FY '85, growing to $30 million by 1989.

Miscellaneous Provisions

Several other provisions warrant attention.

Financial Distress awards were originally intended to rescue the many schools that were then on the verge of collapse due to critical financial circumstances, and were thus unable to meet accreditation requirements or to carry out operational, managerial or fiscal reforms. Circumstances changed and by FY 1983, the Administration was able to justify only a far more narrow objective: "to avoid drastic reductions in school programs and/or school closure, either of which would impair significant training opportunities for minority and disadvantaged students."

The provision for financial distress grants (Section 788A) and advanced financial distress assistance (Section 788B) are likely to be invoked only if the applicant institution has unique characteristics that accord its survival special national importance. While they will probably rarely be used, their retention will enable the Federal government to respond rapidly to a crisis.

The authorities for financial distres grants and advanced financial assistance, outlined in Section 788A and 788B, should be extended with a funding ceiling of $10 million each for FYs 1985-'89.

The Disadvantaged Assistance program is the principal direct Federal program for increasing the presence of underrepresented minorities and other disadvantaged individuals in health careers, by helping to assure that opportunities for minority and disadvantaged individuals in medical education are not inappropriately limited. Funds are awarded through grants and contracts directly to medical schools to support the identification, motivation, recruitment, admission, retention, and placement of minority and disadvantaged students. Current program efforts emphasize increasing the participation of medical schools in developing educational pathways from the high school senior level through professional school.

The Association has long been concerned with the under-representation of minority students in medical schools, and its resultant implications for the delivery of health care services to all sectors of our society. The lower health status of many minority groups in this country is in part attributable to the under-representation of these groups in medical schools.

The inability of medical schools to attract a minority representation reflective of the composition of the society as a whole is due to an array of factors, including lack of adequate educational preparation, the relative absence of role models, and student aid packages not sufficiently enticing to compensate for the less auspicious financial circumstances in which many blacks and other minorities find themselves as they consider medical education. Given these hurdles, many disadvantaged minority individuals who might otherwise be inclined to pursue a career in medicine find the arduous path necessary to attain an M.D. less attractive than other more immediately remunerative, and less costly, career paths.

For these reasons, the AAMC believes that the Disadvantaged Assistance program, which has proven successful in meeting its goal, should be enhanced. The total first year minority student enrollments in medical schools supported by the Diadvantaged Assistance program increased from 674 students in 1972 to 1,108 in 1982. During the same period, minority enrollments in non-supported schools remained relatively stable--501 in 1972 and 517 in 1982. In addition, a higher percentage of students from undergraduate institutions supported by the Disadvantaged Assistance program gained admission to medical school than students from non-supported undergraduate institutions. The Disadvantaged Assistance program is also a potent device for minimizing the high attrition rates experienced by minorities.

Disadvantaged Assistance is clearly an effective mechanism for accomplishing an extremely important objective--increasing minority enrollment and graduation--to which the Association has been long and deeply committed no less than has the Federal Government.

The AAMC thus recommends that Sec. 787 authorities be extended for 5 years, with a funding ceiling of $30 million for FY 1985, increasing $2 million each year through FY 1989.

The Preventive Medicine Residents program provides for grants to support the planning, development, and operation of physician residency training programs in preventive medicine. The program also allows financial assistance (traineeships and fellowships) to residents in such programs who plan to specialize in preventive medicine. In light of the growing emphasis on preventive strategies in the nation, and the program's recent implementation, the AAMC recommends that the authorities in Sec. 792 be renewed for 5 years, with authorization ceilings increasing from $3 to $5 million over that interval.

The Health Professions Special Education Initiatives program supports projects which address high priority health professions issues of national importance. This is the only legislative provision with sufficiently broad discretionary authority to swiftly address major health professions issues as they arise. This program provides grant and contract support for targeted projects in a variety of areas. The program is new and has not been heavily relied upon but could serve important functions and should be reauthorized.

An important component of the special initiatives authorities ~~is~~ in Section 788(c), which authorizes the Secretary to fund continuing education, relief services, and other support mechanisms for physicians practicing in manpower shortage areas. This authority could be particularly useful in the cases where community health centers are in severe financial straits. The Association recommends that these two authorities be extended for 5 years at a level of $15 million per year.

Special Study - The Association welcomes the provision in your legislation which requires a study of the relationship, if any, between levels of indebtedness and specific career choices, along with recommendations for an appropriate policy response to meet any maldistributions of medical specialists. The AAMC has been closely monitoring this very complex relationship, one that is further complicated by the rapidly changing structure of the medical profession. It is clear that debt burdens stand to limit young M.D.s' views of acceptable career options. The Association maintains very detailed data on student indebtedness and looks forward to aiding this study in any possible way.

Overall Summary and Conclusions

The partnership entered into between the federal government and the nation's medical schools through the Title VII legislation has achieved yielded demonstrable and highly benficial outcomes to the nation. Access to medical education has been improved; the quality and number of desired educational programs has increased; and the distribution and specialization patterns of physicians has been altered in accordance with national need. Reports of swelling numbers of physicians has, in the eyes of some, obviated the need for these programs, but a close examination of their results proves otherwise. Most of these programs have highly specific objectives compared to the general aim of increasing physician supply that was embodied in the now defunct capitation program. The federal government still must face a number of pressing health care issues which can be significantly alleviated through involvement and cooperation with the nation's system of medical education. Your legislation serves a key role in maintaining that crucial partnership.

Statement of

The Association of American Veterinary Medical Colleges

For the Record of Hearings

on

Reauthorization of the Health Professions Education Assistance Act

Before the

Senate Committee on Labor and Human Resources

March 14, 1984

The Association of American Veterinary Medical Colleges (AAVMC) is the national veterinary education organization. Its members consist of all 27 U.S. veterinary schools and colleges, and their Canadian counterparts, plus 6 departments of veterinary science in Land Grant universities, and a number of the faculty members in these institutions.

The AAVMC respectfully submits the following statement regarding common programs to be reauthorized under Title VII of the Public Health Service Act. This statement supplements the statement prepared by the Federation of Associations of Schools of the Health Professions, of which the Association of American Veterinary Medical Colleges is a member. We fully support the recommendations of the Federation.

Veterinary medicine is a relatively small, but important, profession. Veterinarians number just over 40,000 in the United States with roughly 2,000 graduating each year. By comparison, nearly 16,000 physicians graduate from American medical schools each year and approximately 40,000 persons graduate from America's law schools each year (as many people graduate from law school each year in the United States as there are veterinarians in total).

The most obvious unique feature of the veterinary profession is the nature and number of our patients. The 40,000 veterinarians in the U.S. provide health care, public health services, and agricultural/food production services to the owners of over 100,000,000 dogs and cats, 175,000,000 cattle and hogs, 8,000,000 horses, and over 4,000,000,000 poultry annually.

Another remarkable characteristic of the profession is the dramatic growth in the number of women becoming veterinarians. Women now represent approximately 50% of all veterinary students in the United States, a remarkable movement toward equal opportunity by any standard. In disappointing contrast, very few minority students have been attracted to veterinary schools, and all minorities constitute less than 6% of the enrollment nationally.

We are pleased to note that graduates of veterinary schools have the lowest default rates in the Health Professions Student Loan program, and there is evidence to suggest similar responsibility in other student loan programs.

The costs of veterinary medical education, like the costs of other health professions educations, have been rising, and we are interested in preserving access to loans for as many eligible students as possible. We particularly favor loans which allow economically disadvantaged students to attend the 27 schools and colleges of veterinary medicine in the United States.

We believe that veterinary students have certain special characteristics: high motivation, an importance to the agricultural infrastructure of America, and a position of responsibility in the care, treatment, and use of animals of all kinds. The average income of veterinarians in the United States was approximately $37,000 in 1980 (the last year for which we have reliable data) — less than half that of physicians. Thus payback requirements suitable for physicians, with potential earnings so much higher than those of veterinarians, may not be appropriate for our graduates. So far, very few of our students are incurring educational debts so large as to threaten bankruptcy when they enter the job market. But this is a matter that needs to be very closely watched over the next few years.

The current system of veterinary education appears to be doing a satisfactory job of producing veterinarians for clinical practice in food animal and companion animal medicine. We presume that there are still significant areas of the country that suffer from shortages of veterinary manpower, but there is no useful data available. We hope that the Department will be able to devote more resources to analyzing the demand for and supply of veterinarians — including companion animal practitioners — in the future.

The current system does not seem to be working very well in providing veterinarians for nonclinical careers. With its low salaries, the academic community has been the most affected. A 1978 study by Arthur D. Little, Inc., funded by the American Veterinary Association, projected substantial shortages in a number of research-related veterinary specialties, e.g., veterinary pathology and laboratory animal care. Similarly, a 1982 study by the National Research Council found the need far exceeding the supply for veterinarians in those federal agencies with public health and safety responsibilities.

A survey of the 1983 veterinary school graduates, conducted by the American Veterinary Medical Association, reveals that very, very few graduates with high levels of educational debt are going into any field other than into private clinical practice. (Only 8% of all the respondents were pursuing any post-DVM training.) A reprint of the results of the survey is attached.

This evidence suggests two different problems with the distribution of veterinarians. One is a shortage of veterinarians in public health-related fields. Another is a shortage of specialty-trained veterinarians in academic and research institutions as well as government agencies. We feel that the in-kind loan repayment proposal of the Federation can help address these problems.

We believe that the shortage of specialty-trained veterinarians also requires more direct action. We recommend that a new subsection be added to Sec. 786 of the Public Health Service Act to authorize grants for traineeship programs in selected veterinary specialties. Fields in particularly short supply are veterinary toxicology, veterinary pathology, laboratory animal medicine, animal welfare-related careers, veterinary epidemiology, and cellular biology.

Summary

Veterinary medicine represents a small but important profession with average earnings less than half of those of physicians. The Association of American Veterinary Medical Colleges respectfully submits that payback terms for federal loans by veterinarians could be ameliorated in the public interest by attaching more favorable payback conditions to veterinarians in particular specialty areas. AAVMC also believes the existing student aid programs need to be continued in their present forms and a new initiative in post-DVM traineeships is required.

Our staff in Washington and members of the association stand ready to provide any assistance we can to the Committee in the development of effective legislation. We thank you for the opportunity to provide these comments.

Economic Note

Educational indebtedness of 1983 graduates of US veterinary medical colleges

In conjunction with US colleges of veterinary medicine, the American Veterinary Medical Association conducted a survey of the 1983 graduating classes of veterinary students. A primary objective was to secure information on educational debt. Of the 1,504 graduating seniors who responded to the survey, 1,500 individuals answered the question, "What will be your total educational indebtedness upon graduation?"

TABLE 1—Educational debt of 1983 US veterinary graduates

Debt level ($)	Relative frequency (%)	Cumulative frequency (%)
0	18.3%	18.3%
1 to 5,000	6.3	24.6
5,001 to 10,000	11.1	35.7
10,001 to 15,000	17.6	53.3
15,001 to 20,000	20.1	73.4
20,001 to 25,000	11.7	85.1
25,001 to 30,000	7.0	92.1
30,001 to 35,000	2.9	94.9
35,001 to 40,000	2.4	97.3
40,001 to 45,000	0.8	98.1
45,001 to 50,000	0.9	99.1
More than 50,000	0.9	100.0
Total	100.0 (1,500)*	

*No. of respondents.

Results of the survey revealed that total educational indebtedness ranged from $300 to $100,000. Approximately 18% of the graduates reported zero debt. Of the 1,225 graduates who indicated having educational debt, the average was $18,897, and the median was $17,800.

The relative frequency distribution showed that 20% of all graduates had an educational debt of between $15,000 and $20,000 (Table 1). More than 25% of all graduates had debt in excess of $20,000; and approximately 2% (27 graduates) reported an educational debt greater than $45,000. About 53% had debt that was less than $15,000.

Average educational debt also was determined by type of employment graduates had accepted at the time of the survey (Table 2). The distribution of graduates by debt level suggested that graduates with high debt chose private practice employment. The exception was graduates going on for advanced study (graduate degree, internship, or residency).

TABLE 2—Educational debt of 1983 US veterinary graduates by type of employment

Debt level ($)	Large animal exclusive	Large animal predominant	Mixed animal	Small animal predominant	Small animal exclusive	Equine predominant	University	Federal government	Military service	State/local government	Industry/commercial	Advanced study	Self-employed	Other
0	1	14	30	31	41	7	4	...	5	...	...	24	14	2
1 to 5,000	...	11	13	10	18	2	1	...	4	...	...	4	3	...
5,001 to 10,000	1	12	17	14	41	5	...	1	1	...	1	17	10	2
10,001 to 15,000	2	24	35	14	56	3	4	...	1	...	...	23	16	...
15,001 to 20,000	4	31	22	19	65	9	1	...	5	1	1	23	16	1
20,001 to 25,000	5	24	16	8	37	3	1	1	...	...	...	15	5	1
25,001 to 30,000	...	9	18	7	21	3	1	...	...	...	...	10	6	...
30,001 to 35,000	1	1	7	4	15	2	...	...	...	...	...	4	...	...
35,001 to 40,000	2	2	3	4	12	2	...	...	...	...	...	4	1	...
40,001 to 45,000	...	1	1	...	3	1	...	...	...	...	...	...	1	...
45,001 to 50,000	...	2	1	3	4	...	...	...	...	...	...	1	...	...
More than 50,000	...	2	1	1	6	...	...	...	...	...	...	1	...	...
Total	16	133	164	115	319	37	12	2	16	1	2	126	72	6
Average debt	$22,400	$18,648	$16,539	[illegible]	$20,160	$20,360	$16,437	$15,250	$11,418	$20,000	$15,000	$19,075	$17,004	$15,750

Prepared by J. Karl Wise, PhD, staff economist for the AVMA, 930 N Meacham Rd, Schaumburg, IL 60196.

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FACT SHEET ON THE NEED FOR REAUTHORIZING THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

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THE CRISIS IN HEALTH CARE

- In 1982, national expenditures for health care totaled $322 billion, or about 10.5 percent of GNP.
- Year after year, national health care expenditures have risen at a faster rate than the CPI. For example, in 1982 health care costs rose 12.5 percent; while the CPI rose by only 6 percent.
- Federal expenditures for Medicare and Medicaid will more than double to $158 billion by 1989--compared with $76 billion spent in 1983.
- Despite the rapid growth in health care spending, a recent survey reported that one American in eight encounters serious trouble obtaining medical treatment.

THE NEED FOR HEALTH SERVICES RESEARCH

> "...We know that the health care system is extremely expensive, and becoming more so, and we are all concerned about finding ways to economize in the provision of health services...but we don't know very much about what we are getting for our health care dollars, how wisely or improvidently we may be spending them...not knowing what we do not know frustrates us in our effort to design more rational policies, and programs, and to more effectively oversee the expenditure of public funds."[1/]

CONTRIBUTIONS OF THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

The work supported by the National Center for Health Services Research has provided federal, state, and local officials with a unique tool for (1) analyzing proposals for change and (2) developing and testing new, more cost-effective

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[1/] Bruce Vladeck, President, United Hospital Fund of New York; Report of the New York City Delegation, January 31, 1984.

methods for delivering health care. For example:

- As a result of health services research, budget savings of $813 million in 1983 and $1.9 billion in 1984 are expected to result from the establishment of a prospective payment system in the Medicare program. The National Center for Health Services Research first supported work on the development of the diagnosis-related group payment system in 1969.
- A relatively small investment in research by the National Center for Health Services Research led to the development of the Computer Stored Ambulatory Record (COSTAR) system. COSTAR has since become the most widely used automatic medical record system in the U.S.
- Research funded by the National Center for Health Services Research developed an analytical tool for policymakers at the state and federal level which will assist them to identify target groups for alternatives to institutionalized care (currently being used by Massachusetts).

CONGRESSIONAL MANDATE FOR HEALTH SERVICES RESEARCH

Over the past four years, Congress has directed the Department of Health and Human Services to carry out a series of studies -- 50 in total -- examining a range of health delivery issues.

In addition to the congressionally-mandated studies, research is also needed in such areas as technology assessment (evaluating the safety and effectiveness of new and existing medical techniques), and the role of market forces in health care delivery.

To meet those demands will require a strong and sustained investment in the programs which support health services research. The Association for Health Services Research recommends that the Congress extend the legislative authority of the National Center for Health Services Research and that the following authorization levels be provided:

Fiscal Year 1985................	$35,000,000
Fiscal Year 1986................	$40,000,000
Fiscal Year 1987................	$45,000,000

The above levels were the authorization amounts available for fiscal years 79-81.

ASPH
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February 1984

ASPH* Health Manpower Act Reauthorization Fact Sheet

Contact: Mike Gemmell

ASPH RECOMMENDATIONS FOR REAUTHORIZATION OF PUBLIC HEALTH TRAINING PROGRAMS

I. Institutional Support (Capitation)

The present health manpower or health professions education act (P.L. 97-35) expires September 30, 1984. The Association of Schools of Public Health (ASPH) urges Congress to continue providing institutional support (capitation) to the 23 U.S. Schools of Public Health over the next three years (FY 1985-87). ASPH requests capitation authorizations of $10 million in FY 1985, $11 million in FY 1986 and $12 million in FY 1987.

History

Federal institutional support to the Schools of Public Health is one of the oldest federal health manpower training programs. This federal assistance encourages the development of experienced public health professionals. Since federal assistance began in 1956, the number of accredited Schools has doubled from 11 to 23 and the enrollment has increased fivefold (over 9,000 students are expected in 1984-85). Yet the amount of federal institutional support has remained at about the same level ($6 million) since 1975.

Justification

Schools of Public Health are distinct from other health professions schools in a number of ways. They are oriented to the community and prevention rather than the individual and cure. Students who attend the Schools are often mid-career professionals with a prior commitment to public service. The average age is slightly over 30. A large percentage are part-time students already working in the public sector while upgrading their skills. It should be noted that a public health degree does not increase the income potential of the graduate as much as other health professions degrees. Schools of Public Health are in the business of training men and women for public service in the areas of health promotion and disease prevention.

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*ASPH is the only national organization representing the Deans, faculty and students of the 23 Schools of Public Health. The Schools represent the primary education system that trains personnel needed to operate our nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

The Schools offer multi-disciplinary training in areas of national shortage and need: biostatistics, epidemiology, health services administration, health education, disease prevention, environmental health, toxicology, occupational safety and health, nutrition and others such as preventive medicine.

Existing health and environmental legislation has created growing manpower needs in public health. The Schools of Public Health are a national manpower training resource for federal and local health and environmental agencies. The demand for public health manpower is expected to increase as Congress continues to enact new programs that improve the quality of life and reduce health care costs. To meet this increasing demand the Schools need additional basic institutional support to maintain and improve the quality of their training programs.

ASPH urges Congress to reauthorize funds for institutional support to Schools of Public Health. Providing support to students and institutions is a means whereby the Federal Government can share the costs with state and private universities for training professionals to operate federally mandated health programs. Teaching costs per student per year approximate those of medical schools, or about $12,000 a year.

II. Student Support (Traineeships)

ASPH requests reauthorization of $5.0 million in FY 1985, $6.0 million in FY 1986 and $7.0 million in FY 1987 for traineeships to students in Schools of Public Health.

History

Federal assistance to encourage development of experienced public health professionals through traineeship support began in 1956. The traineeship program supports graduate or specialized training of health professional personnel in such key public health fields as biostatistics and epidemiology, environmental and occupational health, dietetics and nutrition, health administration, health planning and health policy analysis, preventive medicine and dentistry. Traineeships are awarded to train students enrolled in Schools of Public Health and other public and non-profit institutions which provide graduate or specialized training in public health.

The program is intended to attract high caliber students and to offer the economically disadvantaged, especially minorities, an entry point into the system. The rising cost of tuition and other expenses will make it even more difficult for low-income students, particularly minorities, to afford graduate education in public health schools.

Furthermore, many undertake graduate study in public health at mid-career and have important family obligations. Others have already accrued heavy debts from their previous education. The graduates, unlike many of the other health professions, do not enjoy lucrative incomes. Nearly 80 percent of the graduates are employed by governmental agencies and universities. Their modest salary levels are reflected in a recent survey which showed the mean income for all 1981 graduates at $24,500 with half of the graduates making less than $22,000 (this figure includes physicians and dentists working in public health).*

Justification

A recent HHS report to Congress (January 1982) and several HHS financed studies indicate that the need for public health professionals could double between 1980 and 2000. The proliferation of health programs and agencies has increased--not decreased--the need for trained people in a variety of public health specialities: administration and planning, environmental and occupational health, nutrition and maternal and child health, biostatistics and epidemiology, preventive medicine and dentistry and others. This was substantiated further by the July 1979 Surgeon General's Report Healthy People. Shortages do exist in some key public health fields. Traineeships are ways to ensure that shortage areas are adequately filled.

III. Preventive Medicine and Public Health Residencies (Public Health Physicians)

ASPH requests reauthorization of $5.0 million in FY 1985, $6.0 million in FY 1986 and $7.0 million in FY 1987 to support residency training for students of preventive medicine and dentistry in Schools of Public Health and medical schools.

Justification

ASPH urges the Committee to appropriate funds that provide support to residencies in public health and preventive medicine. Healthy People underlined the need to increase the supply of professionals in these special practice areas. Also a recent Institute of Medicine report, "A Manpower Policy for Primary Health Care," made a number of recommendations including one to increase the number of residency positions in preventive medicine. The October 1980 GMENAC report also urged support for preventive medicine training saying it was definetly a shortage area in medicine.

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*See Attchment A

ASPH concurs with its sister organizations, the American College of Preventive Medicine and the American Teachers of Preventive Medicine, in their efforts to have Congress recognize the special needs of programs in preventive medicine. They maintain that if a change is to be effected in the health care system to bring about a greater emphasis on prevention and cost containment, a change must be made in the attitudes and behavior of the medical profession. Medical students, and hence physicians, are not trained to understand the potential of prevention. Therefore, residencies are needed to promote an awareness of prevention within the medical profession.

IV. Health Personnel Data and Manpower Projections (Data Collection)

ASPH urges adequate support in the new health manpower act for projects to collect, compile and analyze data on health manpower. With the demands being placed on the Schools of Public health to provide data to the executive and legislative branches of the federal government, it becomes imperative that a centralized system of data collection be continued. Because of the need for authentic data produced in a timely fashion, federal funding is necessary to maintain surveillance on public health manpower production in the Schools of Public Health as well as in the other health professions schools.

V. Special Projects (Faculty Development)

ASPH requests reauthorization of $3.0 million in FY 1985, $4.0 million in FY 1986 and $5.0 million in FY 1987 to support special project grants. The special projects grants program began in 1960 but was not reauthorized in P.L. 97-35. It was intended to aid accredited Schools of Public Health to develop new programs and expand existing programs in biostatistics and epidemiology, health administration, health planning, health policy analysis and planning, maternal and child health, environmental and occupational health and dietetics and nutrition.

Project grants provide support for the development of training opportunities in public health to meet emerging national priorities for public health manpower competencies. These include the training of leadership for management and specialized responsibilities in new and projected health areas such as:

- geriatrics
- health promotion/disease prevention
- nutrition
- alcoholism
- toxicology/environmental health
- epidemiology of sexually transmitted diseases
- health care cost containment
- injury due to accidents within and outside the workplace

ASPH believes that these funds will provide support for curriculum development that will enable the Schools to stay current with technological and scientific advances in public health and medical fields. ASPH believes that increases for special project grants would provide the basis generic support for improving the quality of curriculum and teaching techniques to provide health promotion and disease prevention as well as health services management activities in the community, state and Nation.

VI. Summary

ASPH urges the Administration and Congress to support our reauthorization requests and initiate programs that complement the Surgeon General's Healthy People thesis:

> It is the thesis of this report that further improvements in the health of the American people can and will be achieved--not alone through increased medical care and greater health expenditures--but through a renewed national commitment to efforts designed to prevent disease and to promote health.

Further, the Administration and Congress should provide support to another finding of Healthy Prople:

> In the field of public health, in contrast to personal health, manpower shortages are believed to exist in some key fields, including occupational health, epidemiology, biostatistics and health services administration.

ASPH believes that continued federal assistance is actually an investment at the front end of the health care system. The Schools (i.e., through their students, graduates, researchers, faculty and community service programs) will not only help prevent illness, but will also help slow down the rapidly escalating costs of medical care. Providing basic institutional and student support is a means whereby the Federal Government can share the costs with state and private institutions for the training of public health personnel to manage and operate governmental health programs. Public health is a public responsiblity. Schools of Public Health train personnel for public service. The Federal Government has a direct interest in assuring that an adeauate supply of public health personnel is trained in quality intitutions to manage and operate the health delivery system in the national interest.

The Association's recommendatons would provide a means whereby the Federal Government can share costs with the universities for the training of public health professionals in short supply: epidemiologists, biostatisticians, environmental health workers, preventive medicine physicians, among others.

In summary, public health professionals play a key role in maintaining the nation's health.* They are state and local health officers, toxic-waste managers, specialists in controlling epidemics, directors of immunization programs, organizers of preventive health-care programs for the elderly, health educators and administrators of health-service agencies, to cite but a few examples. Such professionals are the main reason drinking water is free of infectious agents, food and beverages are safe to consume and diseases like measles, tetanus and diptheria have been all but eradicated.

Applicatons of the principles and practice of public health have also had dramatic results in more recent memory. The near elimination of polio in the United States and other industrialized nations and the worldwide eradication of smallpox are two recent examples of the effect of public health research and practice.

With the control of infectious diseases, the chronic illnesses are now our major causes of death and disability. Heart disease, cancer and stroke are currently responsible for the majority of all deaths in the U.S. Application of approaches unique to public health, proven successful in controlling infectious diseases, are vital in the effort to limit the toll from these chronic diseases.

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*See Attachment B

ATTACHMENT A

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

HIGHLIGHTS OF THE DATA ON 1981 GRADUATES
Surveyed in February 1982

Employment

1981	78.1%	of the graduates are employed
	12.5%	of the graduates have continued their education
	9.4%	of the graduates are unemployed

Type of Employing Organization

43.8%	of employed graduates work for tax supported orgnizations such as Federal, State, Regional or Local Government
26.8%	of employed graduates work for Voluntary Health Agencies
22.7%	of employed graduates work for Proprietary Organizations

Types of Services Which Graduates are Providing

40%	of graduates are providing Administrative, Planning or Evaluation Services
34.3%	of graduates are providing Technical Services such as Clinical Laboratory, Social and Environmental Services
14.1%	of graduates are providing Education and Training to others in public health
6.8%	of graduates are prviding Public Health Community Organizational Services
4.7%	of graduates are providing Consultation Services

Earning Levels of Employed Graduates

50%	of employed graduates earn less than $22,000 per year

Financial Assistance During Training

58.7%	of graduates depended on traineeships, scholarships, fellowships, grants, loans or employer subsidation as the primary source of funds for meeting educational expenses

Education Related Indebtedness

60%	of graduates reported some amount of education related indebtedness. The mean indebtedness for all graduates (including those reporting no debt after graduation) was $4.565.

ATTACHMENT B

PUBLIC HEALTH EDUCATION

Why It Is Critical To Curbing the High Cost of Health Care

Public health professionals are engaged in preventive health-care--stopping disease before it happens--and reducing injury levels. Thus, they are helping to curb inflation in the $240 billion health-care industry. Yet the Administration wants to terminate federal institutional assistance to Schools of Public health that train these professionals.

The reductions would force the nation's Schools of Public Health to turn away many qualified students, and cut support for faculty, especially junior faculty. This would be an extreme instance of false economy. Here are some reasons why:

- Public health professionals play a key role in maintaining the nation's health. They are state and local health officers, toxic-waste managers, specialists in controlling epidemics, directors of immunization programs, organizers of preventive health-care programs for the elderly, health educators, and administrators of health-service agencies, to cite but a few examples.
- Such professionals are the main reason drinking water is free of infectious agents, food and beverages are safe to consume, and diseases like polio, tetanus and diptheria have been all but eradicated.
- Public health specialists are in short supply. A federal task force recently projected a shortfall of 1,750 in the 7,300 doctors specializing in preventive medicine who will be needed by 1990. Other federal studies project shortages of as many as 10,000 health-service administrators by the mid-1980s, as well as deficits in such fields as epidemiology and industrial hygiene.

The economic benefits of preventive health-care programs have been repeatedly demonstrated:

- Measles immunizaton is estimated to be worth 10 times its costs, resulting from avoidance of the roughly 4 million cases and 400 deaths occurring before mass immunizations began in the early 1960s. Other immunization programs, such as those for rubella and polio, are likewise highly cost-effective.
- Programs like the screening of older men for hypertension, and the use of fluoride to combat dental caries have strongly favorable cost-benefit ratios. The Center for Disease

Control says the $27 million invested by the U.S. in the successful global campaign against smallpox returns that amount in savings roughly every two months, because vaccination programs are no longer needed.

- Common sense suggests many public health measures never analyzed in cost-benefit terms are highly cost-effective. Public health professionals prevented a Venezuelan Equine Encephalitis epidemic in the U.S. in the early 1970s, sparing us the hundreds of thousands of cases, and hundreds of deaths, that occurred in Central and South America. It was a public health professional who blocked approval of the deadly drug thalidomide. More recently, other such professionals have led the successful effort to cut the incidence of toxic-shock syndrome.

- Public health professionals are dealing with the major killers. The mortality rate from cardiovascular diseases dropped 28 percent between 1968 and 1978, meaning more than 300,000 deaths avoided. Changes in diet and lifestyle, many induced by public health education efforts, undoubtedly played a significant role in this reduction.

Despite its cost-effectiveness, prevention is the stepchild of national health policies. Only 4 percent of federal health dollars are spent on it. Yet there is tremendous potential for public health professionals to make further inroads on the high costs of ill health. For example:

- Health of senior citizens--The elderly population is expected to swell from 24 million, or 11 percent of the total to 50 million, or 17 percent, over the next 50 years. Right now, it is estimated at least 25 percent of the elderly have conditions that require regular health-care services. New preventive efforts tohelp the elderly lead healthy lives are badly needed, or the demand on health-care services will drive inflation in the health-care industry to yet higher levels.

- Toxic wastes--Experience has shown that failing to deal effectively with toxic wastes can exact a high cost. The chemical wastes dumped at Love Canal could have been safely disposed of for about $4 million. To date, more than $100 million has been spent to clean up the site, and relocate residents. Public health professionals are needed both to manage the disposal and to allay public fears that the problem is not being brought under control.

- Chronic disease prevention--Comparisons with other industrialized countries show great potential for cutting U.S. death and illness rates for many diseases through prevention. It has been estimated that a minimum of 39 percent of deaths from major cardiovascular diseases 25 percent of deaths

> from cancer and 17 percent of deaths from respiratory diseases could be avoided with improved prevention. These percentages will rise as researchers discover new screening techniques and early treatment methods.

To deal with these and other growing health concerns will require more trained professionals. Not only will the reductions rule that out, they may force large numbers of the 7,000 students currently enrolled in public health schools to drop out. Most of these students, including the minority who are M.D.s, tend to enter public service. Thus, they cannot borrow heavily against high future earnings, as can M.D. candidates who plan to enter private practice. Neither the states nor the private sector can be expected to make up the federal contribution.

Federation of Associations of Schools of the Health Professions

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MEMBER ORGANIZATIONS

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American Association of Colleges of Pharmacy

American Association of Colleges of Podiatric Medicine

American Society of Allied Health Professions

Association of American Veterinary Medical Colleges

Association of Schools and Colleges of Optometry

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Statement of the

Federation of Associations of Schools of the Health Professions (FASHP)*

to the

Senate Labor and Human Resources Committee

Senator Orrin G. Hatch, Chairman

on the

Reauthorization of Health Professions Education Programs

Under Title VII of the Public Health Service Act

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* The American Society of Allied Health Professions is not a participant in the submission of this statement.

FASHP is a federation of associations whose member schools train health professionals. The current members represent the professions of osteopathic medicine, podiatric medicine, nursing, veterinary medicine, optometry, pharmacy, allied health, public health and health administration. Our objectives are to:

(1) improve communication among health professions educational groups,

(2) develop and maintain liaison among member organizations and with other professional organizations,

(3) search for a consensus on the needs of society from the standpoint of education in the health professions,

(4) coordinate the planning of future health professional educational programs, and

(5) demonstrate the effectiveness of health professionals working as members of a team.

In preparation for the reauthorization of federal health professions education programs, consistent with its mission, the Federation has carefully considered how the educational system should prepare to respond to current and future public needs. We are please to provide the Committee with our views. Please note that the following observations and recommendations pertain only to common programs which involve health professions students and schools as a whole. Individual FASHP member associations will separately address programs that involve their unique interests. Allied health and nursing programs, in particular, are not included.

Several significant trends are emerging which will have impact on the demand for health manpower, the patterns of their education, and the health services environment in which they will function. So that the Federation could discuss policy development in the context of these changes, its members collaborated in the preparation of a background paper which speculated on these societal trends and consequent impact on the schools of the health professions. The complete background paper "The Environment of Health Manpower Policy Development in the United States Over the Next Twenty Years" has been made available to the Committee. The trends discussed can be grouped into the categories of socio-political, technological and economic factors. A very brief review of these reveals the following:

Socio-political trends---There are significant demographic changes occurring, such as the increase in proportion of the major ethnic minority groups, the shift in population to the sunbelt states, the increase in the proportion of population over the age of 65, and an increase in the proportion of handicapped and disabled.

Employer-employee relationships are changing. We see a trend toward more very large scale multi-purpose corporations which have remarkable purchasing power for health services on behalf of their employees. For cost containment purposes and improving productivity, there will be increased interest on the part of these and other corporations to sponsor wellness related programs and services.

A third socio-political factor is a continuing major change in the organization, financing, and control of health services. We expect that within a short time most organized health care delivery settings will be a part of multi-purpose systems. That is, we anticipate a continuing decline in the independent, freestanding delivery of health services. We also see continued increase in competition experienced by traditional health services providers, as well as increased competition from nontraditional providers. The organization of health services will also be influenced by a continuing shift from fee-for-services to prepaid plans, by a growth of interdisciplinary working environments, a greater demand and emphasis on ambulatory and home health care, and an increase in innovative delivery systems and models.

All of these trends create a great deal of pressure for a national strategy on health professional education resulting in increased emphasis on understanding disease prevention and promoting wellness. Renewed emphasis on the independent responsibilities of the individual and the development of self-improvement programs are consistent with these trends and certainly must be considered in the training of our health professionals. Also, a better educated public will create higher expectations regarding the quality of services received and the cost effectiveness of social welfare programs.

Technological trends---We anticipate that new technology will be increasingly affecting our daily lives, and at a much more rapid pace. While this can certainly improve the delivery of health services, there will be a concomitant pressure to justify this technology as cost effective. Also contradicting these technological changes will be an increasing expectation to interject human warmth and personal contact into the system.

Economic trends---We anticipate that there will be a moderately expanding economy over the next decade or two, and that this expansion will be due in part to increased productivity. Still it seems clear that containment of health care costs, rather than health itself, will remain a national priority.

Specifically the economic future for health professions schools can best be viewed in light of present constraints. Despite real effort to slow the trend, there have been substantial increases in the cost of education. At the same time, continuing federal deficits have meant: (1) greatly reduced federal funding of educational programs, 2) Medicare/Medicaid reforms with consequent negative effects on financial support of clinical training programs, and 3) no substantial real growth in federal support for biomedical research. Schools are further stressed by reduced student financial aid support and potentially fewer students due to a reduced applicant pool.

Serious budgetary limitations at the state level due to the general economic climate, in some cases exacerbated by the new federalism, prevent the states from increasing their support for education. Private philanthropy cannot overcome the problems of increased costs and decreased revenues. Private foundations, industry, and other private sector groups do not see their role as underwriting basic educational programs.

NEEDS OF THE HEALTH PROFESSIONS SCHOOLS

After reviewing the aforementioned trends, and analyzing the current economic and political climate, the Federation has identified a number of priority needs of schools of the health professions. We tried to limit our thinking to the needs which are of national concern that can be best met through a nationally coordinated effort, and therefore merit the attention of federal policy makers. They are as follows:

(1) STUDENT ASSISTANCE PROGRAMS are needed so that health professions education is not priced beyond the means of average income students, and that such education does not result in a level of indeptedness that adversely affects the cost of providing health care or the careers chosen by students. All schools require programs to assure that students from under-represented ethnic and financial groups continue to have access to education. The quality of the educational experience at every school must be enhanced by students representing the diversity in the public served by health professionals. Existing student assistance programs require strengthening to insure their viability for future health professions students.

(2) FACULTY DEVELOPMENT PROGRAMS are needed to assist existing faculty in methods to improve their teaching skills, to upgrade overall competency in targeted areas such as computers and other new technology, research methods, clinical scientist training, communication skills, administrative management and ethics. In addition, there needs to be support for retraining existing faculty in emerging national priority areas such as toxicology/environmental health, nutrition, and geriatrics/gerontology.

(3) PROGRAMS ARE NEEDED TO SUPPORT INNOVATIVE CURRICULAR CHANGES which will lead to the preparation of health practitioners who are educated with efficiency and well prepared to meet changing societal needs. Multidisciplinary education, health promotion, disease prevention, wellness concepts, cost effective service delivery models, increased communication skills, geriatrics, and ethics all represent areas of curriculum development which merit federal support.

(4) NEW CLINICAL TRAINING SITES must be developed to prepare new practitioners to respond to the continuing need for cost containment, increased emphasis on self-care, disease prevention and wellness, the aging population, and other societal changes noted earlier. Experiences at nontraditional training sites must be incorporated into the education of health professionals

(5) THERE IS AN URGENT NEED TO UPGRADE OLD OR TECHNOLOGICALLY INSUFFICIENT EQUIPMENT AND FACILITIES. Many of our nation's health professions schools are currently utilizing equipment that is outdated, if not obsolete. Academic institutions can neither acquire nor maintain the instruments necessary to conduct research or train students in their use. In many cases, existing facilities need extensive renovation or new construction to accommodate state-of-the-art equipment for research and training. Most health science buildings were built more than thirty years ago and desperately need modernization. The current state of academic physical plants seriously compromises our national capacity for high quality research and, therefore, will erode future productivity and competitive ability.

(6) SUPPORT OF DATA COLLECTION INITIATIVES IS NEEDED. Reliable and comparable data are required on the status of the health professions and their educational institutions. This is essential if policy makers are to be in a position to understand the consequences of past and future decisions. Such data collection currently ranges from good for some professions to non existent for others. The Federation provides a unique vehicle for the federal government and health professions educational institutions to collaborate in a cost effective data collection program. FASHP member associations are now exploring the feasibility of common data collection, and relatively few federal dollars to facilitate and sustain the development of such a program would be well spent.

In summary, there is an urgent need for representatives of all health professions to participate with federal policy makers in the formulation of a coherent approach to supporting the training of health professionals. Toward this end, the Federation has developed a full legislative proposal for essential programs which are common to all health professions schools and students. Our proposal has previously been submitted to you for consideration and is also appended to this statement.

The membership of the Federation appreciates this opportunity to present our views and looks forward to working with the Committee in the coming months as you consider reauthorization of essential national health professions education programs.

Federation of Associations of Schools of the Health Professions

Legislative Proposal for Common Programs to be Reauthorized Under Title VII of the Public Health Service Act

This statement was prepared by the Federation of Associations of Schools of the Health Professions (FASHP) member organizations representing schools affected by Title VII of the Public Health Service Act: American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Colleges of Podiatric Medicine, American Association of Dental Schools, Association of American Veterinary Medical Colleges, Association of Schools and Colleges of Optometry, Association of Schools of Public Health, and Association of University Programs in Health Administration.

It addresses only common programs which benefit health professions students and schools as a whole. Individual FASHP member associations will make recommendations regarding Title VII programs that involve their unique interests. Nursing programs provided under Title VIII are not included.

2/22/84

Federation of Associations of Schools of the Health Professions

Legislative Proposal for Common Programs to be Reauthorized Under
Title VII of the Public Health Service Act

A LOAN IN-KIND REPAYMENT PROGRAM FOR GRADUATES OF HEALTH PROFESSIONS SCHOOLS

In recent years, the costs of attending a health professions school have risen dramatically. It is not uncommon for the student's costs of attendance at a state-supported institution to approach $10,000 per year. As a result, relatively few students can complete a health professions education without incurring educational debts, often substantial. For example, among the 1983 graduates of dental schools, 75 percent of the graduates had student loans in excess of $20,000.

To repay these loans, the graduates must seek relatively high-paying jobs; regardless of their career desires or talents, economics dictate their job selections. An effect of this is specialty-based shortages in some health professions. Quite often, these are public service fields related to public health, preventive medicine or environmental health. Academic and research positions cannot be filled, either, because of the low beginning salaries available.

A cost-effective solution is to create a federal program of loan repayment on behalf of graduates who enter jobs in low-paying, specialty-shortage fields. We have labeled this the Loan In-Kind Repayment (LIKR) program, because the graduate will be paying off most of his or her loan through in-kind service rather than with cash.

The federal government has operated a loan-repayment program in one form or another since the mid-Sixties, generally with good success. Despite this experience, we expect that Congress will want to begin the program at a modest level as a "test." However, in the future the program offers the prospect of becoming a cost-effective complement to the National Health Service Corps (NHSC) program. Whereas the purpose of the Corps is to address manpower shortage, LIKR addresses the distribution of health manpower. By postponing the sign-up time until the graduate is about to enter the workforce, there is a short lead time between the student's decision and the government's identification of need and the provision of service for that need. The students should be able to make more intelligent decisions about desired careers just before graduation than they can in the first years of professional school, as the NHSC scholarship program requires.

The Agreement With the Borrower

The LIKR proposal provides that the borrower will not elect to participate in this program until he or she is ready to enter the workforce. This would be shortly before graduation from the health professions school or near the end of a residency when that is common practice in a profession.

In return for one year of service in a LIKR-eligible job by the borrower, the federal government will repay 20 percent of the borrower's federally-assisted educational loans, up to $20,000 per year of principal repaid. The federal government's aggregate obligation will be no more than 80 percent of the loans, i.e., the equivalent of four years' service by the borrower. At whatever time the federal government completes its obligation, the borrower will commence repayment of the balances owing. During LIKR-eligible service, interest on outstanding loans must be paid by the borrower.

To assure some stability in the program, it is appropriate to require the borrower to make a commitment of at least two years to the specified employment. The Secretary of the Department of Health and Human Services (DHHS) will be authorized to enter into two-, three-, or four-year commitments, depending on projected needs and the borrower's interests. An incidental benefit of this is that the government can pay its obligation at the beginning of the borrower's service, saving enormous sums of money in interest charges that would otherwise be payable on the outstanding loan balances.

A substantial penalty will be imposed upon a borrower who fails to fulfill his or her employment commitment. The borrower will be required to repay to the federal government three times the amount the government has paid on his or her behalf adjusted to reflect the portion of time served. This payment will be due in full one year after the borrower leaves the eligible employment.

The LIKR program will cover federal direct loans as well as federally insured or guaranteed obligations. At the present time, the programs that will be eligible are National Direct Student Loans, Guaranteed Student Loans, PLUS loans to graduate and professional students, Health Professions Student Loans and Health Education Assistance Loans. The federal government's payment obligation will be 20 percent of the totel of the principal per year, with an annual maximum of $20,000. The maximum federal commitment will be for four years and 80 percent of the participant's loans.

Eligible Participants

The LIKR program will be available to schools and colleges of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health and graduate programs in health administration.

Eligible Jobs

The legislation will specify categories of jobs of employers that are eligible job positions for participants in the program. The categories we propose are:

- Teaching and/or research positions in health professions schools.
- State or local public health or environmental protection agencies.
- State or locally owned hospitals, clinics and prisons.
- Nonprofit nursing homes and other long-term care facilities.

- o Civilian federal agencies conducting or sponsoring biomedical research.
- o Civilian state and federal programs for the inspection of meat, poultry and other animal-derived food products.
- o Employment in a health manpower shortage area.

The Secretary of DHHS will from time to time determine which of these fields are in greatest need of health professions and which professions are needed. These decision will be announced by means of notice-and-comment informal rule making published in the Federal Register.

The legislation will direct that the purpose of this program is not the delivery of primary health care, which is the mission of the NHSC. Rather the aim of the LIKR program is to help meet needs in public health, research and teaching that cannot be adequately supplied by traditional health care providers. The Secretary will be directed to develop informal advisory relationships with representatives of the potential employers in order to keep abreast of the needs.

The LIKR program is self-limiting. Some federal, state or local government or private agency must be willing to hire a health professional before the borrower receives any benefit from the federal government. There must also be a borrower willing to take the job. Federal government service may have the same salary drawbacks, or other perceived unattractive features, as state government and academic employment, particularly for health professions with highly specialized training. DHHS will "subsidize" this employment to the extent of the loan repayment; there will be no other payments to the employing agency or the health professional through this program.

Matching Jobs With Graduates

In the implementation of the LIKR program, DHHS will be expected to publicize its existence to health professions students, governors and heads of federal departments and agencies. Recent graduates and LIKR-eligible employers can be expected to find each other on their own.

DHHS will be directed to develop a method by which the governor, cabinet secretary or other appropriate official requests that a particular job be designated as eligible for LIKR participation. If DHHS agrees and an employeee is found, DHHS will undertake to pay the agreed-upon portion of the educational loans. Of course, a monitoring system will be required to assure DHHS that the borrower is in fact serving in the designated position.

Program Costs

We assume that the typical participant in this program will have eligible educational debts totalling $40,000 to $50,000. To enter into a multi-year commitment with the participant, DHHS needs the spending authority that will cover the entire loan repayment period, i.e., $32,000 to $40,000 for the typical participant who agrees to stay with the eligible job for four years. Thus, an apropriation of $20 million in the first year (fiscal year 1985) will allow for the participation of between 400 and 1,250 borrowers. The 400-participant figure assumes each one signs a four-year commitment and has educational debts of $50,000. The 1,250-participant figure assumes each one signs a two-year commitment and has $40,000 of educational debts. For fiscal years 1986 and 1987, we recommend that the authorizations be raised to $25 million and $30 million respectively. This will allow a few more participants in the program, but we anticipate that most of the growth will go to covering the higher average debts of the potential participants who are now in school.

HEALTH PROFESSIONS STUDENT LOAN PROGRAM

Much effort has been focused on this program in recent months. Institutions have made dramatic improvement in loan collection so that today's Health Professions Student Loan (HPSL) program is healthier than ever before.

New Federal Capital Contribution (FCC) Authority

New federal capital contribution authority is needed so that schools that were eligible to receive FCC only for a limited time will be able to build a revolving fund which can sustain itself. A number of schools in the various participating disciplines were opened in the 1970's and received FCC for a very short time apportioned from reduced appropriated amounts. For example, one new school of optometry received only $843 total FCC for fiscal year 1983. That school would need to have $66,000 available yearly in order to make the average HPSL loan of $2,200 to 25 percent of its student body.

The Federation estimates that there are approximately 40 MODVOPP schools with an undeveloped revolving fund. In order to bring the amounts available to the minimum necessary to make awards of $2,200 to 25 percent of their enrolled students, $5 million is critically needed. We therefore recommend that authority for new FCC be included at a level of $5 million in fiscal years 1985, 1986, and 1987.

The schools of Public Health and Health Administration have not yet received funding necessary to participate in this program. If these disciplines are to remain open to students from low income families, they must develop a revolving fund sufficient to meet that need. The Federation recommends a new authorization of $4.0 million, $4.5 million and $5.0 million for fiscal years 1985, 1986 and 1987 respectively, which would be sufficient to establish revolving funds at the 23 schools of public health.
In addition, new authorization levels of $1.3 million in fiscal year 1985, $1.45 million in fiscal year 1986, and $1.55 in fiscal year 1987 is recommended to establish revolving funds for health administration programs.

Distribution of Assets

HPSL revolving funds can, under the current statute, be used to make loans to students only through 1987. After that time, the program is scheduled to go into liquidation; amounts repaid by graduates will revert to the United States Treasury. We recommend extending the date for liquidation of assets to 1992 so that health professions student loans can continue to be made available to needy students.

Authority to Refund the Program

When a school with an established HPSL revolving fund cuts its class size significantly or if that school closes, an "excess cash" balance will result. Currently, all excess cash from the HPSL program reverts to the United States Treasury. We recommend a statutory change which will allow such money to be re-programmed to other schools participating in the HPSL program.

Loan Collection Enhancement

The Federation agrees with administration proposals which would allow schools to raise the amounts they could charge delinquent borrowers as penalties. Currently, institutions may assess a late fee of $1 for the first month a loan is overdue and $2 for each month thereafter. We recommend allowing schools to assess a penalty charge, not to exceed 6 percent of the overdue payment for amounts more than 60 days past due. Such a statutory change would assist schools in their debt collection efforts, and is, in fact, a more stringent penalty than required under the Debt Collection Act of 1982.

The Federation strongly urges that the statute be amended to allow schools access to Internal Revenue Service address lists (skip tracing), to assist them in locating delinquent borrowers. This authority would be especially helpful in locating the nongraduate delinquent borrower.

Finally, we recommend that when schools have made good faith efforts to collect delinquent loans but have been unsuccessul, they be allowed to refer those loans to the government for collection. The school's best efforts are not always as persuasive as a letter from the Justice Department; allowing referral would give us one more tool in pursuing delinquent borrowers.

Regulations Governing the Program

Regulations governing administration of the HPSL program were recently issued by the DHHS. The performance standards set in that regulation were so stringent that many of the health professions schools were threatened with suspension from program participation. The day before schools were scheduled to be suspended for non-compliance, DHHS amended the rule to delay imposition of the performance standard for one year. We believe that the health professions schools and the students who rely on these loans deserve a more stable environment, where program participants receive the classic protections of notice and comment on proposed rules and right to a hearing before suspension.

We believe that schools must be allowed to continue as active participants in the HPSL program so long as their current loan collection practices are in compliance with current HPSL collection regulations, and schools are making good faith efforts to reduce delinquency on loans made prior to 1983.

This could be achieved by providing for the following in the statute:

1. A school's compliance with current regulations shall be measured by a performance standard which is reasonable and achievable for educational institutions.

2. School's administration and collection practices regarding loans made prior to 1983 shall not be reflected in the performance standard. A reporting system shall be devised to assure that schools undertake good faith efforts to collect old loans.

3. Regulations concerning administration of the HPSL program (including 1 and 2 above) shall be developed using the notice and comment process and no school shall be suspended from active participation in the HPSL program without a hearing on the record.

HEALTH EDUCATION ASSISTANCE LOAN PROGRAM

The Health Education Assistance Loan (HEAL) program assures the availability of federally insured loans from non-federal lenders to health professions students. Unlike most federal student financial assistance, interest for the HEAL program is based on the current T-bill rate plus 3.5 percent, with interest calculated quarterly. Because students must be willing to borrow at the market rate of interest to participate, HEAL serves as a loan of last resort for financing the education of health professions students.

Since its 1978 inception, the program has served as an effective fallback for health professions students who have depleted other financial aid resources with lower interest rates. Extension of HEAL's authority for that purpose, namely as an adjunct to other financial assistance programs, is recommended. As educational costs climb, student indebtedness grows, and concern with loan repayment delinquencies continue, the member associations of FASHP encourage only a prudent and cautious expansion of this program.

Historically, authorization levels for this program have grown gradually to the current level of $250 million for fiscal year 1984. In fiscal year 1983, the HEAL program disbursed $161.5 million to borrowers. Fiscal year 1984 borrowing demand is expected to meet or exceed the authorized amount of $250 million. The Federation therefore recommends the following authorization levels for this program:

Fiscal Year 1985	$275 Million
Fiscal Year 1986	$290 Million
Fiscal Year 1987	$305 Million
Fiscal Year 1988	$320 Million
Fiscal Year 1989	$335 Million

To address the potential problem with HEAL delinquencies and defaults, the Federation also recommends limiting the internship and residency deferment period to four years. Because the number of years which may elapse between the time a loan is made until repayment ends, any deferment reduces that time period and subsequently, increases the amount to be repaid each month. Concurrently, increasing interest amounts also accrue. Without limiting the deferment period for those students directly entering an internship or residency program, both factors could potentially increase the occurrences of default.

It is also recommended by the Federation that, contingent upon supporting tuition and income data, graduate allied health students be allowed to participate in this financial assistance program.

DISADVANTAGED ASSISTANCE: HEALTH CAREERS OPPORTUNITY PROGRAM

Health professions education has developed a significant commitment to the recruitment and retention of qualified disadvantaged students. Each health profession can document the degree of success it has achieved in these areas. Despite some degree of success, there still exists significant underrepresentation of minorities and other disadvantaged individuals in the health professions.

It is the FASHP position that in order to provide equal access for the disadvantaged to health professions we need to continue an across-the-board effort to recruit, retain and financially support students from disadvantaged backgrounds in health professions schools. Major strides toward alleviating shortages of minorities and other disadvantaged persons will not be achieved without the involvement of all health professions schools. Federal programs of assistance to disadvantaged students must continue to provide the opportunity for participation by all schools of the health professions. FASHP believes that only through a mass effort will we be able to adequately address the need to increase the number of disadvantaged individuals in the health professions.

FASHP supports efforts directed towards disadvantaged students as defined in 42 CFR 57.1804 (b) (2) and applied currently in the Health Careers Opportunity Program (HCOP). The Federation believes that equal access to health professions must be guaranteed to individuals who are disadvantaged not only by environmental or annual family income but disadvantaged also by education, race or ethnicity and sex. Health professions students selected to participate in HCOP should more adequately represent the broad definition of "disadvantaged." The recommended modifications to current legislation should not alter the categories of health professions students that are eligible to participate in the program.

Because resources for HCOP are limited in proportion to the magnitude of the problems involved in the recruitment and retention of disadvantaged students, it is essential that resources be directed toward applicants with greatest potenial effectiveness. Institutions and organizations eligible to apply for HCOP grants should be limited to health professions schools and national education related organizations. The Federation believes that the health professions schools are best prepared to identify, recruit and retain eligible students. We recommend that these educational institutions be the primary recipients of funding for programs designed to attract and graduate disadvantaged students.

Since the inception of HCOP, national education related organizations have produced several effective models for increasing the numbers of disadvantaged individuals in health professions. Such organizations should continue to develop and provide the largest measure of recruitment assistance, for by virtue of their national focus and discipline-wide representation they can effectively identify potential students in each discipline. Funding preferences need to be refined and focused on the most effective ways for health professions schools and education organizations to accomplish the goals of HCOP.

Recommended authorizations are $24 million, $25 million and $26 million for fiscal years 1985, 1986, 1987 respectfully.

EXCEPTIONAL FINANCIAL NEED SCHOLARSHIPS

Loan programs are available for students from low-income backgrounds but the soaring education-related indebtedness rates for health professions students severely impair schools from attracting and retaining individuals from disadvantaged financial backgrounds. It is important to develop programs for students with "zero financial resources", the criterion used by the Bureau of Health Professions for EFN eligibility, which rely less on loans and more on grants, work programs, and scholarships. Such programs provide access to health professions education for low-income students and at the same time, will not contribute to the problem of defaulting loan debts which ultimately must be absorbed by taxpayers.

The Federation recommends that the exceptional financial need scholarship program be expanded to provide a minimum of two scholarships per year for each public or nonprofit school of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, and veterinary medicine as contained in the current statute. The Federation recommends that these scholarships be made available, also, to each school of public health and each graduate program in health administration. For the 1983-84 academic year, 361 exceptional need scholarships were awarded among currently eligible health professions schools. The scholarships averaged $15,525 for a total expenditure of approximately $5,541,742. Based on these amounts we recommend that 748 scholarships averaging $15,525 be awarded to schools of the health professions, including public health and graduate health administration for a total appropriation of $12,000,000. Specific calculations are below.

Reauthorization Recommendations

Profession	Number of Schools	Number of Scholarships	$ EFN (Average)
Medicine	127	254	$3,943,350
Osteopathy	15	30	465,750
Dentistry	60	120	1,863,000
Veterinary Medicine	27	54	838,350
Optometry	16	32	496,800
Pharmacy	72	144	2,235,600
Podiatry	6	12	186,300
Public Health	23	46	714,150
Health Administration	28	56	869,400
Total	374	748	$11,612,700

CRITICAL INTIATIVES FOR HEALTH PROFESSIONS EDUCATION REQUIRING SPECIAL PROJECT AUTHORITY

Coupled with emerging health concerns, educational institutions must be ready to respond to other social, economic and technological changes which promise to dramatically alter the health care delivery system. The Federation describes such major trends in its white paper, "The Environment of Health Manpower Policy Development in the United States Over the Next Twenty Years" (copy attached). Due to the length of training for health practitioners, health professions schools must now address the needs of society in the year 2000 and beyond.

In order to insure the availability of appropriately trained health professions required for the future, schools must provide for:

1. Faculty Development

   The clinically trained and oriented faculty of health professions schools must improve their teaching skills and be instructed in the use of new educational methods. Their own education did not prepare them specifically to be teachers.

   Also, the overall competency of current faculty in targeted areas including computer and other new technology, research methods and clinical scientist training, communication skills, administration management and ethics must be upgraded. Beyond these general needs, faculties must acquire educational expertise in high priority specialty areas such as toxicology/environmental health, nutrition, gerontology and other profession-specific disciplines.

   Since financial restraints will largely prevent schools from expanding their teaching staff, development programs must be established for existing faculty in these areas.

2. Innovative Curricula

   Faculties must examine existing curricula to insure that they adequately cover the full range of subjects all students require. Wellness concepts, health education/promotion, disease prevention, the importance of self-care, the special needs of the elderly, and communication skills necessary for practitioners must be emphasized in professional curricula. In addition, students must be prepared to address the ethical as well as economic considerations involved in health care decisions.

   Continuing budgetary pressures mean faculties will seek more cost effective education and service delivery models. In this light, multidisciplinary approaches to educational programs need to be explored.

3. New Clinical Training Sites

   Because the health care delivery system is undergoing significant change in response to the need for cost containment, emphasis on prevention, the aging of the population, and many other societal changes, health professions schools must develop non-traditional clinical training sites and opportunities which are consistent with these trends. New community based sites must be considered, as well as realistic simulation of clinical encounters.

The Federation recommends that special project support be reauthorized for these broad needs shared by all schools. This recommendation reduces the list of possible initiatives in current statute from an unmanageable twenty-four to the three highest priority areas.

Special Projects

Health professions educational programs are the responsibility of each institution and its faculty. However, given the substantial increase in the cost of education and the limitations of institutional and state budgets, individual schools do not have the resources to respond to national needs on their own. The historical partnership of the federal government and schools in addressing high priority national concerns must be maintained.

Therefore, the Federation recommends continuation of special project authority with the following refinements:

1. Competition by Profession

   We are concerned that existing statutory provisions lack definition and have allowed the exclusion of various professions in activities relevant to national needs. To assure each health profession of opportunities to develop its unique responses and knowledge, special project funds should be allocated to each profession for distribution within that profession on the basis of competitive application.

2. Priority Setting and Review

   Within broad purposes and authorities provided in statute, it is our belief that each profession is best equipped to determine those areas in which special project support can most effectively be utilized to enhance the development of skills and knowledge within that profession. The educational institutions of each profession must be involved in the process of priority designation for special projects. Therefore, we recommend that the statue specify development of general national health professions education priority guidelines by the Health Resources and Services Administration, in consultation with the health professional school associations. Further, it should be required that special project grant proposals be subjected to peer review and that final funding recommendations to the DHHS Secretary be made by the Health Professions Educational National Advisory Council.

3. Two Special Project Categories

   Demonstration, Evaluation and Dissemination - - In each health professional school group, grants should be available on a competitive basis to develop models and demonstrate new approaches to the needs outline above (three special initiative areas). Completion of these projects will benefit each group as a whole, and health professional education in general.

Implementation - - Separate and distinct from the need for development and dissemination of model approaches, all schools may require assistance in implementing program changes needed by their institution. Therefore a separate authorization and competitive process should be established for each health profession to address the unique and highest priority needs identified by schools.

3. Adequate Authorizations

Under health professions special initiatives we recommend annual authorizations of $10 million; $1 million each for school of medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, health administration (programs), and allied health; for demonstration, evaluation and implementation. An additional $10 million should be authorized annually for implementation.

MATCHING GRANTS FOR RENOVATION OF TEACHING FACILITIES FOR HEALTH PROFESSIONS AND GRANTS FOR INSTRUMENTATION AND EQUIPMENT

Pursuant to Title VII, Part B of the Public Health Service Act, the federal government contributed more than $1 billion to the nation's health professions schools between 1965 and 1975 for constructing and equipping teaching and research facilities. Subsequent to 1975, however, the government reversed its policy of encouraging an increase in the numbers of health professionals, and the flow of dollars for construction and equipment purchase slowed to a trickle.

Due to the cutoff of federal support for this program many of our nation's health professions schools are currently utilizing equipment which is outdated if not obsolete. In many cases, existing facilities will need fairly extensive renovation to accommodate state-of-the-art equipment for research and training.

The sorry state of our national research capacity is just beginning to receive the serious attention it deserves. A 1980 study conducted by the Association of American Universities(AAU) examined the current status of university facilities, and found a serious erosion of our national capacity for high quality research, including health science research. The report concluded that there were ". . . problems in the acquisition, use and maintenance, of research instrumentation ... in all of the leading universities visited." Moreover, AAU said, "many facilities are in need of renovation or replacement."

The AAU study found that both U.S. industry and foreign universities are outdistancing American universities in research capability. The problem, said the report, was the escalating cost of equipping facilities at a time of decreasing federal funding. "Signs that aging facilities now impede research were found in many laboratories and support facilities," the report concludes.

In a 1983 report, the National Commission on Student Financial Assistance, Subcommittee on Graduate Education expressed great concern about the current state of education in the sciences, including the health sciences:

> Our investment in sophisticated, expensive and powerful equipment and instrumentation is inadequate. It is not simply a matter of not keeping pace - - our penury has led to a situation in which many existing instructional labs and much of the equipment and instrumentation currently available are obsolete and insufficient to the tasks at hand.

In the face of this regrettable erosion of our capacity for high quality education and research in the health sciences, FASHP proposes a two pronged effort to:

1. Assist health professions schools in securing access to up-to-date equipment and instrumentation; and

2. Where necessary, assist in modernizing existing physical plants in order to accommodate state-of-the-art educational instruction, and to conduct first rate research in the health sciences.

We ask that Congress provide a modest start-up program in this important area. In order to receive funds for renovation of facilities under this program, schools will be required to match the amount of any federal grant by means of nonfederal contributions. Authorization levels of $15 million for each of the fiscal years 1985, 1986 and 1987 would provide such a program with a strong beginning.

AREA HEALTH EDUCATION CENTERS

In 1978, new funding was established for schools of medicine and osteopathy for planning, development, and operation of Area Health Education Centers (AHEC). Requirements included the participation of one or more schools of medicine or osteopathy, and at least two other health care disciplines. Dentistry must be included if there is a school affiliated with a university with which the school of medicine or osteopathy is affiliated. The AHEC is also required to conduct a training program for physicians assistants or nurse practitioners.

The 1981 Reconciliation Act made substantial amendments to the AHEC statute. Priority and funding was given to AHECs which carry out projects that have positive impact on supply and distribution of health personnel.

There seems to be substantial interest in the AHEC program, and a dissatisfaction with the current level of participation by health professions schools other than medicine and dentistry. As a result, the Federation is making two legislative recommendations for the AHEC program. An extension of this program's current authorization level, $24 million, is recommended for the next three fiscal years. In addition, the Federation recommends the inclusion of a requirement to encourage multidisciplinary training and practice involving health professions.

ADVANCED FINANCIAL DISTRESS

The Federation supports continuation of advanced financial distress grants through the current cycle.

The Environment of Health Manpower Policy Development in the United States Over the Next Twenty Years
by the
Federation of Association of Schools of the Health Professions*

In our discussions of the factors in society which will influence the development of health manpower policy in the United States, we focused on those which are most likely to have some impact on demand for health manpower, the patterns of their education, and the health services environment in which they will function. The factors identified can be loosely grouped into three primary categories: socio-political, technological, and economic. Again, it is important to emphasize that our objective is not to comprehensively identify all of the trends in our society which will affect health care or indeed, society in general. It is to hone in on those for which there is the implication of an impact on education. The question ultimately must be asked by the health manpower education community, "So what?" What does this trend in our society have to do with the development of health manpower? Having identified the impact, the next question is does this impact mandate a response in public policy at the federal, state, or local level, or does it mandate a response from the private sector, or some combination thereof? And then, what is the appropriate response desired?

The legislation which authorizes the federal government to support health manpower expires this year, thus causing us to take stock of the federal role in the education of health professionals. Also, it is a pivitol time, for it has been twenty years since the federal government entered aggressively into the business of supporting the education of various kinds of health manpower, and the year 2000 is roughly twenty years away. Given the significant changes in the role of the federal government relative to health services and all of education, it is imperative that the leadership of health professions education, the leadership on our campuses, and the relevant national organizations understand themselves the new environment of manpower education and provide leadership in helping the communities with whom they interact to understand the new environment. It is also important that recommendations for a new health manpower policy of the federal government be developed on the basis of a tight rationale which looks forward to that new environment. It is not appropriate, nor politically viable to approach new legislation by looking back, that is, by making the argument that support to the professions should be continued because support existed before. The argument must be based on a defined appropriate role for the federal government in balance with appropriate roles for other governments, students, and the educational institutions themselves. Other elements of the private sector may also play an important role.

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* Presented at the Annual Meetings of the Association of Academic Health Centers, September 28, 1983 and the American Council on Education, October 14, 1983.

Continued

Again, our thinking goes as follows: First identify trends which will likely have an impact on education, then identify the impact, then determine how that will influence needs, and finally determine how the public or private sector can most appropriately respond. This paper only identifies trends and impacts. We use this meeting to validate and elaborate on our projections so that we may move on to the development of the second part of this position paper, that which makes recommendations regarding appropriate public and private sector roles.

Social-Political Trends

Demographic Changes

First, let us look at socio-political trends.

We assume that there will be major changes in the demographics of American society. In fact, the rate of change may be greater and more visible than it has been at any time since the decrease in European immigration early in this century. We have identified four principal changes in the demographics which bear on our concerns.

The first are the changes in ethnic mix. Because of birth rate differentials and immigration, we will see continued growth in the number and percentage of the American population identified as latino, black, or oriental. Each of these cultural, ethnic, and racial orientations brings particular perspectives and approaches to family structure. This has implications for housing patterns, fertility rates, and care of the aged. There are distinct views of institutionalization, for example, which mandate a highly refined approach to consideration of health facility needs in relation to population and age distribution. They bring distinctive languages with unique terminology which present communication challenges with implications for the education of practitioners who work with them. Individuals of different cultural and social backgrounds seek the use of a wider variety of practitioners and relate to practitioners of all kinds on particular ways. There is a large body of knowledge from sociology focusing on the idiosyncracies of various groups in their relationships to health services and health practitioners.

The political implications of this change in ethnic mix are profound. This country is no longer strongly motivated by a melting pot philosophy which assumes that all citizens move toward a homogeneous model. We are now strongly stressing the pluralism of this society, and thus we can conclude that the political visibility of these emerging communities will be increasingly important. It is no longer clear when a minority is a minority. Major political subdivisions are in fact governed by, or dominated by, one or another subgroup of American society, and within those political entities, the subgroup is a majority by every definition. This development coincides with the changing notion of the role of various government levels and the devolution of polital responsibility to levels which are closer to the people. Thus, programs will need to be responsive to the unique tastes and different sets of priorities which will dominate the political process at local levels.

The second major factor in demographic development is the shift in population distribution to the so-called "sunbelt." This trend has been alluded to

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repeatedly by John Naisbitt as a very significant factor in the future patterns of development of the country. The hub city phenomenon identified with the marketing strategies of major airlines is also a reality in projecting growth patterns of cities themselves. That is, the major urban growth will be in the middle range sized cities which offer most of the amenities of the largest cities, but with less congestion and urban tension. To the extent that middle range cities hold concentrations of specific subgroup of American society, they can be expected to claim access to specialized human service facilities including health services and higher education. An example of this is the large influx of elderly people to Arizona.

The third factor in demographics is, of course, the increased proportion of the population over the age of 65. The Arizona Coalition for cost effective quality care represents a quarter million elderly Arizonans and reflects the increasing visibility of the aged. Similarly, it can be anticipated that in certain populations there will be a decrease in the number of children as a proportion of the population. The future impact of a population reflecting fewer school-aged children upon public support for revenue-producing initiatives is well known.

The final element in demographics is one which is little recognized for its potential potency and impact on health services. That is, the substantial projected increase in the proportion of handicapped and disabled among the population. This increase is a result of increased life expectancy associated with many diseases and health conditions, and the trend to move people out of institutions for rehabilitation. Certainly this will increase the number of individuals out in society with certain handicaps and thus create certain demands on health services.

Employer-Employee Relationships

A second major factor in the social environment of the next two decades is a changing employer-employee relationship. There will be a new pattern of relationships which may, to some extent, reflect the influence of the Japanese model, but has its origins in other causes as well. And the issue is not one of unionization or non-unionization despite decreasing union membership and confrontations between productivity and employment security.

The first contributing factor is that the pattern of business size and corporate structure is changing toward a larger number of very large scale multi-purpose corporations, and a smaller number of middle range sized firms. These large scale organizations are tending to offer employees a wide variety of opportunities to use the company as a focal point for their interests. In some Fortune 500 companies, it now appears that the employees are spending an increasing amount of non-job-related time at the company taking part in health, education, hobby, and social welfare activities. It is an interesting return to an earlier day when some contended that companies were intrusive into the daily lives of their employees. But in the current social environment, it has taken on a very different flavor. Both employers and employees seem to be increasingly accepting of a broader relationship. And it is in the area of wellness-oriented activities that this new relationship is

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most dramatic. Firms are providing an increasing variety of wellness-related services in response to their cost containment potential. One of the current debates among benefits officers concerned with cost containment outcomes of their wellness strategies is the extent to which release time during the work day is appropriate and can be demonstrated to be cost effective. Some firms have currently reached an anticipated ceiling of participating employees, and yet wish to attract more employees into wellness related activities outside of working hours. The purely cost benefit justification seems not to be the only motivation.

Organization of Health Services

The third major assumption within the socio-political frame of reference has to do with the organization of health services. There will continue to be major changes in the organization, financing, and control of health services. The recent Lewis-Harris study for the Equitable Life Assurance Society clearly demonstrates that the public strongly favors major changes in the organization of health services and is politically favorable to government intervention should private initiatives fail to respond to their concerns.

There are several factors which we believe are propelling the rapid changes in organization. The first of these is that most organized health care delivery settings will within a very short time be part of multi-purpose systems. There will be, of course, variations in the extent to which they are responsive to the direction of the parent organization, or the confederation in which they participate. But the fact is that the free standing delivery of health services which must rely totally on the institution's own resources is rapidly becoming the exception. There are estimates that among hospitals, for example, 80 percent will be part of such groups within from two to five years. The percentages and the years vary, but the trend is clear. What is less apparent is the extent to which this phenomenon extends beyond the hospitals. Nursing homes are increasingly moving into chain organization. One chain which is among the top three has commented that well established independent nursing homes are coming to them with offers to sell out at a rate which far outruns the chain's ability in terms of financing or management depth. Similarly, the relatively new phenomenon of ambulatory emergency centers or surgery centers is largely a chain development resulting from both the development of new facilities and the absorption of existing facilities. Centers join such chains to seek the capital flow or marketing competence of the parent organizations.

A second propellant of the assumption for organizational change will be the increased competition experienced by traditional health services providers. This competition will come from each other as is commonly assumed, but it will also come increasingly from non-traditional providers. The Harris study demonstrated public interest in and support for a wide variety of health practitioners and alternative delivery systems. We have already pointed out the relationship between the sociology of population subgroups in the United States and their attitudes toward traditional practitioners, and indeed, their demand for sources of care which are in keeping with their cultural traditions. This will be a factor in the competition from non-traditional providers. The proposed new medical staff standards of the Joint Commission

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on Accreditation of Hospitals (JCAH) tips its hat to the right of individual hospitals to determine which are the appropriate practitioners to use its facilities. This non-prescriptive approach is in contrast to previous tight definitions of who can practice in a hospital. It not only reflects the trend of devolution of authority to the community level but also an anti-trust reality which reduces the ability of the traditional providers to limit access and legitimacy by their less traditional competitors.

The third factor is the continuing shift from fee-for-service to prepaid plans. There are several factors which lead us to conclude that the current growth in prepayment will continue and indeed accelerate. While it is true that the more optimistic prognoses for HMO growth have not been fulfilled, it is also true that they have grown, and that the conditions for their growth are improving constantly. The most important condition is public familiarity with the phenomenon. In many communities, prepaid plans are no longer exotic, but are accepted alternatives, particularly for young families. Capitation for Medicaid and Medicare enrollees is clearly a politically attractive approach to cost containment and to predictability of health service costs. It can be comfortably predicted that DRG-type reimbursement in some combination with capitation may lead to a stronger financial base for prepaid plans. Employers must increasingly turn to approaches which give them the protection of predictability as well. Finally, there is the increasing M.D. willingness to by employed, reflecting both increased familiarity and comfort with the setting, as well as the fact that more doctors need jobs.

Continued growth of interdisciplinary working environments is another propellant of organizational change. It is the continuation of a trend that has been the focus of a great deal of professional conversation over many years. Although some would argue that effective interdisciplinary patient care has rarely been achieved and that there is a mythology of teamwork, we would argue that the convergent impact of all of the assumptions laid out herein will be to encourage the continuation toward more, rather than fewer, interdisciplinary health services. Competition among health services delivery organizations will lead to an effort to find new ways to be productive in manpower utilization, innovative delivery systems will use their interdisciplinary flavor as a marketing strength, and stricter reimbursement programs will force reconsideration of task allocation among health providers.

The fifth propellant of change is the greater demand and emphasis on ambulatory care and home health care. The most immediate indicator of that demand will be the DRG pressure to move people out of the hospital. JCAH has figures showing more than 2,000 ambulatory centers of one kind or another which have potential for independent accreditation. Ambulatory centers are clearly not a passing phenomenon but one for which there appears to be a ready market. Despite the debate over the cost effectiveness of home health care, particularly as it serves as a replacement for family-provided services, there is the common notion that it is better than the high cost, high tech alternative. Part of its value is the fact that the patient is at home relating to the family, and the family is involved in the treatment or rehabilitation process. Again, we refer to the sociological imperatives and the fact that we have an increasing influence by cultures which are less institution oriented and more extended family oriented.

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The final major propellant is the increase in innovative delivery systems and models. The bases for continued increase are all in place. The regulatory environment which includes the JCAH is moving to legitimize a wider variety of delivery models. The reimbursement system is becoming more open-ended and indeed, in some cases, actively seeks alternative delivery models. We have mentioned the substantial number of free-standing ambulatory centers of one kind or another. They are increasing, by some estimates, on the order of two to three a week. The hospice is rapidly developing in importance. It is not longer an experimental volunteer-based activity at the margins. There is formal accreditation for hospices and there is reimbursement for hospices.

One interesting new technological development which further argues for de-institutionalized care is home alert monitoring systems. These systems place a communications device in the home of a high risk individual thus assuring the immediate communication of an urgent problem to the provider organization. Does this fortell even the monitoring of vital signs by remote systems which may be tied into either the doctor's office or an ambulatory clinic of one kind or another? Again, I refer you to the Harris Poll, with its somewhat surprising finding that a substantial majority of the administrators of leading hospitals favor such developments designed to reduce inappropriate or high cost hospital use.

Another of our basic assumptions is that there will be a substantial increase in the effectiveness of public educational systems. There will be an increasing emphasis on the effectiveness of basic education in primary and secondary grades, with a number of significant consequences for the social environment of health services and the education of health manpower. One result is a better informed and potentially more discriminating public. Public education in the United States is currently at a low point and there is no debate about the inadequacies of the system. The critical factor is that primary and secondary education are very close to fundamental social values and aspirations. New populations, either new in arrival, new in size, or new in political clout, will support strong schools particularly if a national strategy for improvement emerges. Unquestionably, any national strategy for curriculum improvement will reflect an increased emphasis on understanding disease prevention and promoting wellness.

Another outcome of increased educational system effectiveness will be higher expectations regarding the quality of services received and the cost effectiveness of investments in social welfare programs. Public education levels already include a strong consumerism flavor, which, when combined with an emphasis on wellness/prevention and environment, will raise the sensitivity of young people to the quality and impact of all kinds of services which affect their daily lives.

The final assumption within the socio-political framework is that there will be an expansion of the current re-emphasis on the independent responsibilities of the individual. There has been a strong trend in that direction in this country in part due to the decreasing influence of the melting pot philosophy and the concomitant resurgence of emphasis on pluralism. In a pluralistic society, who knows best? We see three specific contributing trends. The first is that the individual will have more individual authority for investing benefit dollars. Employers will be less directive and more interested in

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designing benefit programs to include incentives to change behavior, a process built on the encouragement of informed individual behavior and individual responsibility for the outcomes thereof.

A second factor we have already discussed, that is, the tendency to turn to and accept the services of alternative practitioners and delivery systems. Not only does this changing pattern of utilization follow from the increasing pluralism in society, but also from the competitive force previously identified.

The third force underlining the assumption of increased independent responsibility is the rapidly expanding involvement in self improvement activities of all kinds--not only for health but also for personal advancement. Enrollment trends in higher education are now forcing institutions to consider repackaging their services and reaching broader audiences. This is happening at exactly the right time in terms of the technical obsolescence of productivity challenges of this society. We have said that employees will be spending an increasing amount of their optional time in activities which center on the place of work. Many of those activities will, of course, be of an educational self advancement nature. We know that the shift of population geographically reflects changing employment patterns. We also know that many individuals who were separated from their usual work in the last five years will not be re-employed and face the need for retraining. Thus the demand for self learning opportunities will increase. And new technology is expanding these opportunities. In the last few weeks, an announcement was made that a new for-profit corporation will market educational satellite television-linked services nationwide. This new corporation will enable universities and corporations to reach out in a matter somewhat akin to the British Open University.

So far we have discussed only socio-political changes.

Technological

The second major area of development after the socio-political is the technological. It has been said many times in many places that society is becoming increasingly technologically based, yet we have been technologically based for many years. What is meant is that new technology will be introduced into our daily lives at a much more rapid pace. Daily living will be increasingly impacted, whether it is through the telephone, television, automobile, or any other utensil or factor in the comforts of life or in the process of doing business. Technology is increasing, touching all of us at a personal level.

On one hand, the increasing rate of technological change will have an immense impact on the nature of health services. First, there must be an accommodation between the pressures for high technology investment and cost containment efforts. A dramatic illustration in terms of corporate policy comes from the fact that the Hewlett-Packard Company is in the business of inventing and marketing very high technology based health services equipment with a very high price tag. The President of Hewlett-Packard is on a hospital

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board which wants the freedom to purchase whatever equipment it feels it needs to retain its competitive position, and at the same time, his company is aggressively pursuing cost containment policies in the community which are designed in part to limit the ability of hospitals and other institutions to invest in unnecessary, duplicative, or overly expensive high technology equipment. Also to be considered is the view of John Naisbitt that the human reaction to the increasingly high tech environment of health services will be a countervailing demand for high touch services. We should anticipate more demand for services which bring human warmth and personal contact into the system, those which maintain the human dimension which we so easily extoll as being the essence of health services, but which are so easily denied in our organizational innovation.

Economic

Finally, it is appropriate to touch on the economic environment as we close the twentieth century. Our assumption is that there will be a moderately expanding economy, and that expansion will be due in part to increased productivity. There will be increasing competition for disposable or discretionary income. We have said that a substantial portion of the work force has been made obsolete by technical changes in the last five years, and that more will be made obsolete by technological innovation in the next decades. it is entirely probable that the long-term trend toward a shorter work week will continue, both as a response to the increasing productivity of a technologically based society and as a result of social policy designed to minimize unemployment. A shorter work week converges with our earlier discussion of orienting free time toward the work place, pursuing self improvement, particularly of an educational nature, and having increased individual responsibility for the disposal of benefit and other kinds of income.

There will be increased political pressure to contain costs and at the same time to provide services. We must anticipate increased political oversight of the allocation of health dollars at all levels of government.

DRAFT NUMBER THREE
FEBRUARY 23, 1984
ALB: HEALTH

98th Congress
2d Session

S___

To amend the Public Health Service Act to revise and extend the programs of assistance under Title VII of such Act for the education of health professions personnel, and for other purposes.

IN THE SENATE

-----------,1984

Mr.[Ms.] __________ introduced the following bill; which was referred to the Committee on ____________________

A BILL

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Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as "The Health Professions Authorization Act of 1984".

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SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as "The Health Professions Authorization Act of 1984".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

FINDINGS AND PURPOSES

Sec. 2. The Congress finds that the following points deserve priority consideration in the formulation and development of Federal health professions programs:

(1) In recent years, costs of attending a health professions school have risen dramatically. Students must bear undergraduate educational debt in addition to the costs of their professional education. As a result, relatively few students can complete a health professions education without incurring substantial educational debts.

(2) In order to repay these loans, graduates often must seek relatively high-paying jobs; regardless of their career desires or talents, economics dictate their job selections. An effect of this is speciality-based shortages in some health professions. Quite often, these are public service fields related to public health or preventive medicine or environmental health. Academic and research positions cannot be filled because of the low salaries.

(3) Significant underrepresentation of minorities and other disadvantaged individuals in the health professions still exists. Efforts to recruit, retain and financially support students from disadvantaged backgrounds in health professions schools must be continued. Major strides in providing minorities and other disadvantaged persons with educational opportunities and access to health professions careers will not be achieved without the involvement of all health professions schools.

(4) Geographic and speciality based shortages of some types of health professionals continue to exist.

(5) Educational institutions must be ready to respond to other social, economic and technological changes that promise to dramatically alter the health care delivery system. Due to the length of training for health practitioners, health professions schools must now address the needs of society in the year 2000 and beyond.

(6) Many of our nation's health professions schools are currently utilizing equipment that is outdated if not obsolete. Academic institutions can neither acquire nor maintain the instruments necessary to conduct research or train students in their use. In many cases, existing facilities need extensive renovation or new construction to accommodate state-of-the art equipment for research and training. Most health science buildings were built more than thirty years ago and desperately need modernization. The current state of academic physical plants seriously compromises our national capacity for high quality research and, therefore, will erode future productivity and competitive ability.

TITLE I - CONSTRUCTION OF TEACHING FACILITIES AND ACQUISITION OF EQUIPMENT AND INSTRUMENTATION

Sec. 101. Section 701(6) is amended by --

(1) inserting "(A)" after "(6)"; and

(2) adding the following at the end thereof:

> "(B) The term "equipment and instrumentation" means equipment, devices, tools, and any other medical or scientific instrumentation dedicated for use by students, faculty, or administrative or maintenance personnel for clinical purposes, research activities, libraries, classrooms, offices, auditoriums, or other related purposes necessary for, and appropriate to, the conduct of programs of education.".

Sec. 102. (a) Section 720(a)(1) is amended to read as follows:

> "(a)(1) The Secretary may make grants to assist in the construction of teaching facilities and the acquisition of equipment and instrumentation for the training of physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.".

(b) Section 720(b) is amended to read as follows:

> "(b) There are authorized to be appropriated for the purpose of making payments under grants under subsection (a), $15,000,000 for the fiscal year ending September 30, 1985, and for each of the two succeeding fiscal years, to remain available until expended.".

Sec. 103. Section 721(b)(1) is amended by --

(1) inserting "or acquisition of equipment or instrumentation" after "construction of any facility"; and

(2) inserting "or acquire equipment or instrumentation" after "construct a facility".

Sec. 104. (a) Section 721(c)(2) is amended by --

(1) inserting ", equipment or instrumentation" after "the facility" in subparagraph (A);

(2) inserting "in the case of an application for a grant to assist in construction of a teaching facility," after "(B)" in subparagraph (B); and

(3) inserting "in the case of an application for a grant to assist in construction of a teaching facility," after "(C)" in subparagraph (C).

(b) Section 721(c)(4) is amended by inserting "in the case of construction of teaching facilities," after "(4)".

(c) Section 721(c)(7) is amended by inserting "in the case of an application for a grant to assist in the construction of a teaching facility," after "(7)".

(d) Section 721(d) is amended by inserting "for construction of teaching facilities" after "applications for grants".

(e) Section 721 is amended by inserting the following at the end thereof:

> "(h) The Secretary shall by regulation provide for proper review of all grants and contracts under this part by utilizing to the maximum extent possible appropriate peer review groups composed principally of non-federal experts.".

Sec. 105. Section 722(c) is amended by inserting "for assistance in construction of a teaching facility" after "the amount of any grant".

TITLE II - STUDENT ASSISTANCE

Sec. 201. Part A of title VII is amended by adding the following new section at the end thereof:

"Sec. 711. All regulations affecting part C of this title shall be promulgated in accordance with the notice and comment procedures for informal rule-making as provided in 5 U.S.C. 553, with a minimum period of 60 days for public comment.".

Sec. 202. Section 728(a) is amended by --

(1) striking out the last sentence thereof;

(2) striking out "and" after "1983;";

(3) inserting the following before the period:
";$275,000,000 for the fiscal year ending September 30, 1985; $290,000,000 for the fiscal year ending September 30, 1986; $305,000,000 for the fiscal year ending September 30, 1987; $320,000,000 for the fiscal year ending September 30, 1988; and $335,000,000 for the fiscal year ending September 30, 1989"; and

(4) striking out " September 30, 1987" and inserting in lieu thereof "September 30, 1992".

Sec. 202. Section 729 is amended by inserting "a postbaccalaureate degree program in allied health," after "chiropractic," each place it appears.

Sec. 203. (a) Section 731(a) (2) (B) is amended by inserting "(however, such repayment shall begin after the borrower has been a participant in internships or residency programs for four years)" after "internship or residency program".

(b) Section 731(a) (2) (C) is amended by inserting "(except in the case of internships and residency programs under clause (ii))" after "shall not be included."

TITLE III - STUDENT LOANS

Sec. 301. (a) Section 740(a) is amended by --

(1) inserting "public health," after "optometry"; and

(2) inserting ", or any graduate program in health administration," after "veterinary medicine".

(b) Section 740(b) (4) is amended by inserting "or doctor of pharmacy" after "bachelor of science in pharmacy" and inserting "master or doctorate of public health or an equivalent degree, master of health administration or an equivalent degree," after "doctor of optometry or an equivalent degree,".

(c) Section 740 is amended by adding the following new subsections at the end of thereof:

> "(c) An agreement with a school or program entered into pursuant to subsection (a) may be terminated by the Secretary, in accordance with the procedures of this subsection, upon finding by the Secretary of failure by the school or program to comply substantially with the requirements of Sec. 745. The procedures that the Secretary shall follow to effect a termination shall include at least the following procedural steps:
>
> > "(1) The Secretary shall provide the school or program with written notice that the school or program appears not to be complying substantially with the requirements of section 745, and the Secretary shall furnish a written statement of reasonable and achievable steps which the school or program may take to demonstrate progress toward achieving substantial compliance with those requirements.
> >
> > "(2) The Secretary shall afford the school or program a reasonable opportunity (at least 30 working days) to demonstrate that the school or program has substantially complied with the requirements of Section 745 or has taken reasonable actions to demonstrate significant progress toward achieving substantial compliance.
> >
> > "(3) If the Secretary determines that the school or program's response is not adequate, then the Secretary shall notify the school or program in writing of the Secretary's intent to terminate the agreement with the school or program and of the school or program's opportunity for a formal hearing. If the school or program requests such a hearing withing 30 days, the hearing shall be conducted by an administrative law judge who shall consider all evidence offered at

the hearing and prepare findings of fact and made a determination whether a school or program has complied substantially with the requirements of section 745. In making such determination, the administrative law judge shall give appropriate consideration of extenuating factors, which may include but are not limited to the following --

"(A) if the school or program has relatively few borrowers who are repaying these loans, a rigid delinquency performance standard may not be appropriate.

"(B) the relative number of borrowers who did not graduate;

"(C) the relative number of borrowers who are repaying their loans;

"(D) the progress the school or program is making in collecting past-due accounts;

"(E) the economic conditions of the area in which the school or program's graduates have located;

"(F) administrative problems beyond the control of the current officials responsible for loan collection; and

"(G) the legal enforceability of any delinquent loans.

"(4) (A) Except as provided in subparagraph (B), the determination of the administrative law judge shall be binding on the parties and becomes effective thirty days after issuance of the administrative law judge's findings of fact and determination under Section 740(C)(3).

(B) Any school or program may, within thirty days following the decision of the administrative law judge, request a review of such decision by the Secretary. If such request is made, the Secretary shall conduct such review and make the required determination based on consideration of all information submitted to the administrative law judge and any other information submitted by the parties. In conducting such review and making such determination, the Secretary shall affirm the finding and determination of the administrative law judge, unless they are unsupported by substantial evidence based on the record taken as a whole.

"(5) A school which has requested a hearing pursuant to Section 740(C)(3) and has requested a review of that decision by the Secretary pursuant to Section 740(C)(4), shall be considered to have exhausted its administrative remedies and shall be entitled to judicial review in a U.S. District Court.

(d) Until an agreement with a school or program entered into pursuant to Section 740(a) has been formally terminated by the Secretary pursuant to Section 740(C), the school or program shall continue have access to all funds available under Section 740 to make student loans.".

Sec. 302. Section 741(j) is amended by --

(1) inserting "(1)" after "(j)";

(2) sticking out the second sentence and inserting in lieu thereof "Such charge, not to exceed six percent of the installment, may be assessed for each month by which such installment or evidence is late, provided that the installment is not less than sixty days late."; and

(3) adding the following new paragraph:

"(2) Notwithstanding any other provision of law, upon a written request to the Internal Revenue Service, a school shall have access to address lists maintained by the Internal Revenue Service which may assist the school in locating delinquent borrowers.".

Sec. 303. (a) Section 742(a) is amended by --

(1) inserting "(1)" after "(a)";

(2) striking out "and" after "September 30, 1983,";

(3) inserting the following before the period: "$5,000,000 for fiscal year ending September 30, 1985, and for each of the two succeeding fiscal years";

(4) inserting the following new paragraphs at the end thereof:

"(2) For the purpose of making Federal capital contributions into the student loan funds of schools of public health which have established such funds under section 740, there are authorized to be appropriated $4,000,000 for the fiscal year ending September 30, 1985, $4,500,000 for the fiscal year ending September 30, 1986, and $5,000,000 for the fiscal year ending September 30, 1987.

"(3) For the purpose of making Federal capital contributions into the student loan funds of graduate programs in health administration which have established such funds under section 740, there are authorized to be appropriated $1,300,000 for the fiscal year ending September 30, 1985, $1,450,000 for the fiscal year ending September 30, 1986, and $1,550,000 for the fiscal year ending September 30, 1987.".

(b) Section 742(b)(3) is amended by adding the following at the end thereof: "The Secretary shall allot funds authorized for each of the fiscal years after the fiscal year ending September 30, 1984, to schools that have established such student loan funds after July 1, 1972.".

(c) Section 742 is amended by adding the following new paragraph at the end thereof:

"(5) In the case of a school at which a student loan fund has been established under section 740 which, for whatever reason, reduces its enrollment significantly or closes, if an excess cash balance in the student loan fund exists, such funds shall be returned to the Secretary for allotment under this subpart.".

Sec. 304. Section 743 is amended by striking out "1987" each place it appears and inserting in lieu thereof "1992".

Sec. 305. Subpart II of part C of Title VII is amended by adding the following new section at the end thereof:

"STUDENT LOAN INFORMATION BY INSTITUTIONS

"Sec. 745. (a) With respect to loans made by a school or program pursuant to this subpart after June 30, 1985, each school or program, in order to carry out the provisions of sections 740 and 741, shall, at the time such school or program makes a loan to a student borrower under this subpart, provide thorough and adequate loan information on loans made under this subpart to the student borrower. The loan information required by this subsection shall include--

"(1) the yearly and cumulative maximum amounts that may be borrowed by a student;

"(2) the terms on which repayment will begin;

"(3) the maximum number of years in which the loan must be repaid;

"(4) the interest rate that will be repaid and the minimum amount of required monthly payment;

"(5) the amount of any other fees charged to the student by the lender;

"(6) any special options the borrower may have for deferral, cancellation, prepayment, consolidation, or other refinancing of the loan;

"(7) a definition of default and the consequences to the borrower if the borrower should default; including a description of any arrangements made with credit bureau organizations; and

"(8) to the extent practicable, the effect of accepting the loan on the eligibility of the borrower for other forms of student assistance.

"(b) With respect to loans made after June 30, 1985, each school or program, in order to carry out the provisions of sections 740 and 741, shall, immediately prior to the graduation from such school or program of a student borrower under this subpart, disclose to the student borrower the information required under this subsection. The disclosures required by this subsection shall include--

"(1) the itemization of and the total amounts financed, calculated by adding all amounts borrowed by the student borrower under this part, and subtracting all charges, paid by the student borrower;

"(2) the dollar cost to the student borrower of the amount borrowed;

"(3) the dollar amount of total scheduled payments, calculated by adding the amounts in paragraphs (1) and (2); and

"(4) the repayment schedule of the student borrower, including the number, amounts, and frequency of payments.

"(c) The loan information required by subsections (a) and (b) shall be made available in a conspicuous form either in the note or other written evidence of the loan or in another written form signed by the borrower.

"(d) Each school and program, in order to carry out the provisions of sections 740 and 741, shall maintain contact with any student borrower on loans made under this subpart during any period of deferral of repayment of such loan which begins after June 30, 1985 (as permitted in section 741 (c)) following the borrower's graduation from such school or program. Such required contact with the borrower shall consist of letters to the borrower which summarize the information required in subsections (b)(4), and such letters shall be sent by the school or program to the borrower approximately 90 days after the borrower's graduation, approximately 180 days after said graduation, and at approximately 30 days prior to the date the first payment on a loan made under this subpart is due.

"(e) With respect to loans made pursuant to this subpart which are not delinquent as of June 30, 1985, and with respect to any loans made pursuant to this subpart after such date, a school or program, in order to carry our the provisions of sections 740 and 741, shall take the following actions whenever a borrower under this subpart fails to make one or more loan payments in accordance with the repayment schedule contained in the loan agreement between the borrower and the school or program:

"(1) The school or program shall notify the delinquent borrower of the status of the borrower's loan account and the consequences of default at the following intervals--

"(A) approximately 15 days after payment is due;

"(B) approximately 45 days after payment is due;

"(C) approximately 60 days after payment is due;

"(D) approximately 75 days after payment is due;

"(E) approximately 120 days after payment is due.

"(2) If all of the notices required under subsection (e)(1) have failed to cure the delinquency, the school or program shall take the following actions whenever the costs incurred by the school or program in such actions do not exceed the amount owed:

"(A) notify the credit bureau of which the school or program is a member of the overdue account;

"(B) use collection agents, which may include the use of an internal collection agent; and

"(C) institute legal proceedings the borrower after all other attempts at collection have failed, provided that such litigation is appropriate.

"(f) With respect to loans which are delinquent as of June 30, 1985 the school or program shall take the following action whenever the costs incurred by the school or program in such actions do not exceed the amount owed:

"(1) The school or program shall pursue all reasonable methods available for locating borrowers.

"(2) If a borrower is located, the school or program shall send the borrower a registered letter, restating the borrower's obligation to repay the loan and the consequences of default. The borrower shall be given 30 days to respond before further actions are taken.

"(3) A nonresponding borrower shall receive two additional registered letters, indicating the future actions the school or program will take to collect the loan.

"(4) A borrower who has not begun to repay the loan within 120 days after the initial notification by registered letter shall be subject to the collection efforts described in subsection (e)(2).

"(g) If a school or program has complied with all the requirements of this section and the loan remains delinquent, the Secretary shall accept referral of this loan for collection by such means as may be at the disposal of the federal government. Any amounts collected on a loan referred to the Secretary shall be paid over to the loan fund of the school which referred the loan. If any such loan fund has been liquidated, any amounts collected by the Secretary shall be distributed among the loan funds of participating schools in accordance with the provisions of section 742(b)(3)".

TITLE IV - OTHER SCHOLARSHIPS

Sec. 401. (a) Section 758(a) is amended by --

(1) inserting "public health," after "podiatry,"; and

(2) inserting ", or graduate program in health administration" after "veterinary medicine".

(b) Section 758(b) (2) is amended by inserting before the period "except that the total scholarship award for that year shall not exceed the cost of education for that year at the educational institution".

(c) Section 758(d) is amended by --

(1) striking out "and" after "1983,"; and

(2) inserting before the period ", $12,000,000 for the fiscal year ending September 30, 1985, $13,000,000 for fiscal year ending September 30, 1986, and $14,000,000 for fiscal year ending September 30, 1987.".

Sec. 402. (a) Section 781(c) is amended by adding the following at the end thereof: "In the case of an area health education center in which more than two other health professions schools or programs are actively participating with the school of medicine or osteopathy, the Secretary shall provide additional funds under the grant for such center in consideration of each additional participant school or program.".

(b) Section 781(g) is amended by inserting ", and for each of the three succeeding fiscal years" after "September 30, 1984".

TITLE V - DISADVANTAGED STUDENTS, FINANCIAL DISTRESS

Sec. 501. (a) Section 787(a)(1) is amended by inserting "paragraph (3) and" after "determined in accordance with".

(b) Section 787 (b) is amended by --

(1) striking out "and" after "September 30, 1983,"; and

(2) inserting the following before the period: "$24,000,000 for the fiscal year ending September 30, 1985, $25,000,000 for the fiscal year ending September 30, 1986, and $26,000,000 for the fiscal year ending September 30, 1987".

Sec 502.(a) Section 788 is amended by striking out subsections (a), (c) and (d) and redesignating subsections (b), (e) and (f) as subsections (a), (b) and (c), respectively.

(b) Section 788(a) (as redesignated above) is amended to read as follows:

"(a) (1) The Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, and graduate programs in health administration and allied health, and other appropriate public or nonprofit private entities, for health professions projects and programs to--

"(A) demonstrate, evaluate, and disseminate; and

"(B) implement; special projects in the health professions.

"(2) Grants made and contracts entered into under paragraph (1) shall include projects and programs to --

"(A) provide faculty development, including --

"(I) enhancement and improvement of the teaching skills and education methods of faculty of such schools;

"(II) training for faculty of such schools in computer technology, research methods, communications skills, administration management, ethics;

"(III) training for faculty of such schools in specialty areas such as toxicology and environmental health, nutrition and gerontology;

"(B) plan, develop and establish innovative curricula, including --

"(I) course materials in health education and promotion, disease prevention, self-care, the special needs of the elderly and communications skills; and

"(II) multidisciplinary approaches to educational programs,

"(C) establish new clinical training sites to provide training consistent with changes in the patient population, emphasis on cost effective education and service delivery models, importance of prevention, and reduced financial resources, including non-traditional community based sites and training by simulation of clinical encounters when appropriate.

"(3) The Secretary shall prescribe general notional health professions education priority guidelines in order to establish priority projects in each project category described in subsection (b). Such guidelines shall be prescribed in consultation with health professions schools.

"(4) In awarding grants and entering into contracts under paragraphs (1), the Secretary shall evaluate proposals from schools by comparing those proposals with others from schools providing training in the same profession.

"(5) The Secretary shall by regulation provide for proper peer review of all grants under paragraph (1) by utilizing to the maximum extent possible appropriate peer review groups composed principally at non-federal experts. The Secretary shall submit all proposals for peer review. The Secretary may not make grants or enter into contracts under paragraph (1) until the Secretary has received the recommendations of --

"(A) the peer review committees; and

"(B) the Health Professions Education National Advisory Council.".

(b) Section 788(c) (as redesignated above) is amended by --

(1) inserting "(1)" after "(c)", and

(2) inserting the following new paragraphs at the end thereof.

"(2) (A) For purposes of subsection (a) (1) (A), there are authorized to be appropriated $10,000,000 for the fiscal year ending September 30, 1985, and for each of the two succeeding fiscal years.

"(B) For purposes of subsection (a)(1)(B), there are authorized to be appropriated $10,000,000 for the fiscal year ending September 30, 1985, and for each of the two succeeding fiscal years.

"(3) With regard to the funds authorized to be appropriated under subparagraph (A) of paragraph (2), $1,000,000 shall be designated for each of the following health professions schools under each such subparagraph: medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, health administration, and allied health.".

TITLE VI - LOAN-IN-KIND REPAYMENT PROGRAM

Sec. 601. (a) Part C of title VII is amended by adding the following new subpart after subpart II:

"SUBPART III - LOAN-IN-KIND REPAYMENT PROGRAM

"Sec. 747. (a) The Secretary shall establish the Loan-In- Kind Repayment Program (hereinafter in this subpart referred to as the "Repayment Program") to assure an adequate distribution of trained health professionals and to provide a program through which the graduate of a health professions school may reduce his education debt through service in academic, nonprofit research, or community or public service employment.

"(b) To be eligible to participate in the Repayment Program, an individual must--

"(1) be within one year of graduating from an accredited school or program in a State offering a degree in medicine, osteopathy, dentistry, or other health profession (or within one year of completing an approved internship, residency or other advanced clinical training program);

"(2) submit an application to participate in the Repayment Program;

"(3) sign and submit to the Secretary, at the time of submittal of such application, a written contract (described in subsection (e) to accept payment of designated loan amounts on his behalf (contingent on finding and securing an eligible employment position under this subpart) and to undertake full-time employment for the designated period; and

"(4) have obtained a loan in support of his health professions education under --

"(A) the National Direct Student Loan Program (20 U.S.C. 1087aa et seq.);

"(B) the Guaranteed Student Loan Program (20 U.S.C. 1071 et seq.); or

"(C) loan programs under this title.

"(c) In disseminating application forms and contract forms to individuals desiring to participate in the Repayment Program, the Secretary shall include with such forms --

"(1) a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under section 748 in the case of the individual's breach of the contract; and

"(2) information respecting meeting a designated employment obligation under an agreement and such other information as may be necessary for the individual to understand the individual's prospective participation in the Repayment Program and designated employment positions.

"(3) The application form, contract form, and all other information furnished by the Secretary under this subpart shall be written in a manner calculated to be understood by the average individual applying to participate in the Repayment Program. The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Repayment Program on a date sufficiently early to insure that such individuals have adequate time to carefully review and evaluate such forms and information.

"(d)(1) An individual becomes a participant in the Repayment Program only upon the Secretary's approval of the individual's application submitted under subsection (b) and the Secretary's acceptance of the contract submitted by the individual under subsection (b).

"(2) The Secretary shall provide written notice to an individual promptly upon the Secretary's approving, under paragraph (1), of the individual's participation in the Repayment Program.

"(e) The written contract (referred to in this subpart) between the Secretary and an individual shall contain --

"(1) an agreement that --

(A) subject to paragraph (2), the Secretary agrees (i) to provide the individual with repayment (described in subsection (f) for a period of years (not less than two nor more than four years) determined by the individual, during which period the individual is engaged in full-time employment in an eligible employment position; and

"(B) subject to paragraph (2), the individual agrees to engage in full-time employment for a time period (not less than two nor more than four years) in accordance with section 749;

"(2) a provision that any financial obligation of the United States arising out of a contract entered into under this subpart and any obligation of the individual which is conditioned thereon, is contingent upon funds being appropriated for loan repayment under this subpart;

"(3) a statement of the damages to which the United States is entitled, under section 748 for the individual's breach of the contract; and

"(4) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this subpart.

"(f)(1) Repayment under a written contract shall consist of payment to, or (in accordance with paragraph (2)) on behalf of, the individual an amount equal to 20 percent per year of the principal of the individual's federally-assisted educational loans (as provided in subsection (b)) not to exceed $20,000 for each year of service. Such repayment shall not exceed 80 percent of the principal of the individual's eligible loans. Eligible employment may not be less than two nor more than four years under the Repayment Program. Nothing in this section shall preclude the Secretary from prepaying all or part of the eligible amount of an individual's eligible loans.

"(2) The Secretary may contract with a lender of eligible loans for the payment to the lender of the principal amounts on behalf of the individual. Payment to such lender may be made without regard to section 3648 of the Revised Statutes (31 U.S.C. 529).

"(g) The Secretary shall report to Congress on March 1 of each year --

"(1) the number, and type of health professions employment that individuals undertake under the Repayment Program;

"(2) the amount of loan principal paid in the aggregate in each year; and

"(3) the number of applications filed for participation in the Repayment Program.

"Sec. 748. (a) Except as otherwise provided in this section, if an individual breaches his written contract by failing either to begin such individual's employment to complete such employment, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A = 3\phi(t-s/t)$$

in which "A" is the amount the United States is entitled to recover, "ϕ" is the sum of the amounts paid under this subpart to or on behalf of the individual; "t" is the total number of months in the individual's period of employment; and "s" is the number of months of such period served by him in accordance with a written agreement under section 747 (e). Any amount of damages which the United States is entitled to recover under this subsection shall, within the one year period beginning on the date of the breach of the written contract, (or such longer period beginning on such date as specified by the Secretary for good cause shown) be paid to the United States.

"(b)(1) Any obligation of an individual under the Repayment Program (or a contract thereunder) for service or payment of damages shall be canceled upon the death of the individual.

"(2) The Secretary shall by regulation provide for individuals to remain participants in the Repayment Program in good standing in the case of individuals who do not retain their employment while such individuals seeks new positions eligible under the Repayment Program.

"(3) The Secretary shall by regulation provide for the partial or total waiver or suspension of any designated repayment penalty by an individual under the Repayment Program (or a contract thereunder) whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"Sec. 749.(a) An individual participating in the Repayment Program shall enter into a contract with the Secretary to undertake full-time employment in the categories of public health, research, and teaching as specified in subsection (b).

"(b) Designated employment under this subpart is as follows:

"(1) Teaching and/or research positions in health professions schools.

"(2) State of local public health or environmental protection agencies.

"(3) State of locally owned hospitals, clinics, and prisons.

"(4) Nonprofit nursing homes and other longterm care facilities.

"(5) Civilian federal agencies conducting or sponsoring biomedical research. The principal agencies are the National Institutes of Health, the National Science Foundation, the Agriculture Research Service, the Food and Drug Administration, and the Environmental Protection Agency.

"(6) Civilian state and federal programs for the inspection of meat, poultry, and other animal-derived food products.

"(7) Employment in a health manpower shortage area designated under section 332.

"(c) Eligible participants under this subpart for repayment under the Repayment Program are graduates of schools and colleges of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health, and graduate programs of health administration.

"(d) The Secretary shall from time to time prescribe regulations designatimg which of these fields are in greatest need of health professionals and which categories of professions are needed.

"(e) The Secretary shall publicize the existence of the Repayment Program, the fields in greatest need of health professionals, and the employment verification procedure and distribute such information so that it is available to health professions students, health professions schools, governors, and administrators of federal, state, and local departments and agencies.

"(f) The Secretary shall prescribe regulations to implement this subpart, including regulations establishing a procedure whereby a particular position is determined to be a designated employment position and a monitoring system whereby the Secretary verifies that each individual participating in the Repayment Program is complying with the terms and conditions of the contract with the Secretary.

"Sec.750. There are authorized to be appropriated for repayments under this subpart $20,000,000 for the fiscal year ending September 30, 1985, $25,000,000 for the fiscal year ending September 30, 1986, and $30,000,000 for the fiscal year ending September 30, 1987.".

HOWARD UNIVERSITY
WASHINGTON, D.C. 20059

OFFICE OF THE VICE PRESIDENT
FOR HEALTH AFFAIRS

March 23, 1984

Senator Orrin Hatch
Chairman
Health Subcommittee
United States Senate
Washington, D. C. 20510

Dear Senator Hatch:

I appreciate having the opportunity to submit written comments, for the record, on proposals to reauthorize the Nurse Training and Health Professions Programs under Titles VII and VIII of the Public Health Service Act.

As you are aware, this nation has benefited substantially as a result of these federally mandated programs. Talented individuals who would have been unable to receive the necessary training for careers in the health professions because of a lack of adequate funding have been given the opportunity to do so. More importantly, urban and rural communities which, heretofore, had been overlooked by medical personnel seeking more-lucrative areas for their practices are now being served by graduates of the programs. Studies reveal, however, that a shortage still exists in many areas and in many specialties. I, therefore, applaud your efforts to extend these programs.

I understand the importance of reducing the federal debt and balancing the budget, but statistics have shown that the availability of adequate medical care actually reduces the drain on future federal dollars. Preventive health care, rehabilitative, and gerontological services are just a few examples of services which can be deterrents to overwhelming medical expenses in the coming decade.

I also want to note, as indicated in the testimony by our own Dr. Clive O. Callender before your Committee on Organ Transplants earlier this session, that minority persons are less healthy than other American citizens. Specifically, minorities have a higher incidence of infant mortality, a higher incidence of renal failure, and do less well when transplanted than do other groups. Therefore, targeting resources to help train individuals to care for these persons, who generally reside in poor urban and rural communities, would be cost effective. Channeling funds into programs to conduct research into the causes of the problems cited above would also make sense, as indicated by proponents of nurse research funds.

My colleagues in the Association of Minority Health Professions Schools have cited similar concerns in the testimony they presented on this subject. While we are all concerned about proposed cuts in the Administration's FY 1985 budget in the various health programs, we are confident that you, Senator Kennedy and other members of your Committee will continue your efforts on our behalf.

Yours very truly,

Carlton P. Alexis

Carlton P. Alexis, M.D.
Vice President for Health Affairs

CPA:baw

March 14, 1984

James F. Glenn, M.D.
President
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ISSUES OF MEDICAL MANPOWER AND MEDICAL CARE

Grave concerns about medical manpower have been voiced by many authoritative sources, including several government commissions. The most prominent of these was the Graduate Medical Education National Advisory Committee, or GMENAC, sponsored by the Department of Health and Human Services and chaired by Dr. Alvin Tarloff, then Professor of Medicine at the University of Chicago School of Medicine and presently director of the Henry J. Kaiser Family Foundation. Many of the leaders of organized medicine participated in this study over a period of some two years.

It is clear from the GMENAC study and from other similar prospective and retrospective analyses that we are in a posture of potential overproduction of physicians. This situation may be deleterious to health care delivery, and most certainly it is not cost effective. The reasons for this are diverse but interrelated, and deserve the scrutiny of congressional committees concerned with these matters.

Let me begin by addressing the question of why we are in this position of overproduction. Historically it should be remembered that the nation suffered a shortage of physicians shortly after World War II, particularly in terms of medical specialists. A great effort was then made to gear up our residency training capabilities to produce the specialists that we perceived were needed.

This acceleration of qualified residency training programs was a laudable and major accomplishment of the medical education enterprise. We were able to increase numbers of specialists in virtually every discipline, and today it can safely be said that there are shortages of medical specialists in only a handful of areas. These include both adult and child psychiatry, emergency medicine and, in some areas of the country, family practitioners. Other specialties seem to have been very well served by this expansion of residency training capability.

During the same period, the total number of physicians available for health care delivery was increased. The federal government's initiative in this effort was to offer financial inducement to schools of medicine to increase their enrollments. Medical school deans were told that if they would increase enrollment by a factor of 20 percent, they would receive capitation grants that would cover not just the 20 percent increment but rather 100 percent of all students enrolled. On the other hand, if enrollment was not increased by 20 percent, no capitation support would be given. The consequence of this is quite obvious. All of the medical schools expanded their capacity and increased their enrollment in response to this inducement.

Similarly, it was a federal initiative to increase the number of medical schools. From 1950 to 1984, the number of approved medical schools in the United States grew from 80 to 127. This represents an increase of some 60 percent in the total number of schools, with each school enrolling an incrementally larger number of medical students.

The net result has been that in the past thirty to thirty-five years, we have increased the capacity of our medical schools to produce from approximately five to six thousand graduates a year to a total now of nearly 17,000 new physicians annually. Graduates of medical school do not enter the pool of practicing physicians immediately. They go through periods of residency training that vary from three to eight years, depending upon the specialty, but ultimately they will enter the pool.

This might not be a drastic problem, except that concurrent with this increase in numbers of physicians being produced, attrition of physicians is at an all time low. The percentage of physicians who are retiring or ceasing to practice for one reason or another is diminishing, while the number of physicians entering the practice pool is increasing at an accelerated rate. (The average age of physicians is falling, and now approximates 37 years of age.)

Let me provide a numerical perspective. In 1982, there were some 480,000 physicians in the United States, of whom approximately 375,000 were actively engaged in the practice of medicine. With the incremental increase in number of graduates, we can anticipate that the pool of practicing physicians will accelerate at a rate of five percent annually. This means that in twenty years' time we will double the number of physicians in practice, if no changes in public policy occur.

Skeptics and critics argue that a larger number of physicians in the practice pool will be beneficial. They contend that more doctors will mean more competition, and more competition will drive down prices of health care. Experience has shown that this is not the case, and that medical manpower is utilized to its fullest, regardless of the size of the available manpower pool. The reasons for this are not totally obscure, but are somewhat complex.

Most important, I believe, is the fact that our patients cannot be expected to know to what extent they should utilize medical manpower, or medical technology, which is so terribly expensive today.

Also, the appetite for consuming medical care is virtually unlimited. All of us when ill, no matter how minor our complaint, would like the undivided attention of the physician. We would also like to take advantage of all available technology, from the very selfish but very human perspective of being certain that we are being adequately diagnosed and treated.

The question of whether greater numbers of physicians would accomplish a redistribution of medical manpower to solve the problem of geographical maldistribution also remains moot. It has been demonstrated in recent months that 80 percent of the country's population lives within ten miles of a physician or an adequate health care facility. Ninety-eight percent of our population lives within 25 miles, or a short driving time, of adequate medical care. Only two percent live in areas that are so sparsely settled that they could not be expected to attract or sustain a physician. These statistics were reported in the New England Journal of Medicine, October 25, 1983.

We must also take the practicalities of the situation into account. Very few physicians are anxious to locate in an area where they do not have adequate tools to practice modern medicine. Today's doctors are trained to employ the best in laboratory technology, radiologic techniques and the various other accoutrements of modern medical practice. To isolate oneself from this modern technology is considered a retrogressive step by most doctors.

Similarly, doctors are loathe to locate in areas that cannot provide the cultural advantages they enjoyed in obtaining a medical education, usually in a metropolitan center. They are unwilling to deprive their families of those educational and cultural opportunities.

Finally, a physician is very unlikely to settle in areas where there is no opportunity for cross-fertilization of ideas by frequent professional exchanges, no opportunity to call on a colleague for help with a difficult diagnostic or therapeutic problem, no opportunity to share the responsibility for community health care, and no opportunity even to take calls for one another and thus have some leisure time.

It, therefore, seems unreasonable to expect that even with a massive oversupply of physicians, we will ever see a totally satisfactory distribution of doctors, although the study that recently appeared in the New England Journal of Medicine suggests we are achieving a reasonably good distribution.

If there do not appear to be advantages to producing an oversupply of physicians, what are the disadvantages? First and foremost, it should be recognized that every physician who enters the practice pool today accounts for an average of over $300,000 of health care expenditures annually. This figure is based on the individual physician's utilization of hospital beds for his or her patients, medications prescribed, and use of medical technology and diagnostic capabilities. It is obvious, then, that the larger the number of physicians, the greater the total cost of health care to the public and ultimately to the taxpayer.

We also know that a larger number of practicing physicians will not bring down the cost of professional fees. In fact, it has been demonstrated that quite to the contrary, each doctor must sustain a certain level of income in order to meet expenses. If the costs of education, malpractice insurance, office overhead, and the various other cost factors of a medical practice can be spread over a larger base of patients, the cost of individual health care is lower. If those same fixed base costs must be spread over a smaller number of patients, each patient will pay proportionally more for the same services from the same physician.

Virtually every doctor enters practice today burdened with a predetermined debt related to his or her medical education. It is estimated that by 1986 that debt may approach $60,000 per physician. By 1990, the debt might easily be of the magnitude of $100,000. This debt must be amortized and interest paid over the interval of that physician's practice.

The cost of medical malpractice insurance has soared along with the cost of medical education, due primarily to the staggering sums awarded by the courts in medical malpractice actions. For example, a neurosurgeon in the greater New York area is faced with a medical malpractice insurance fee of more than $50,000 a year. Similar rates are common around the country, particularly in the more populous states. The physician must pay these fees as an overhead item before any personal income is generated, because no physician can afford to be without some form of insurance coverage today.

A major expense item today also relates to office overhead. No doctor can practice medicine without some form of an office base. In the metropolitan areas, physicians are often forced to purchase property in order to establish an office. The purchase price may run to several hundred thousand dollars in areas such as New York's upper east side. These costs must also be amortized against practice income.

As we look at the rather staggering financial obligation that the physician undertakes, it is no wonder that the cost of medical care could be driven upward by an oversupply, for each doctor incurs similar operating overhead expenditures.

Our problem with medical manpower is further compounded by certain ill-advised policies regarding admission of foreign trained physicians to the United States. This includes not only foreign-born and foreign-trained physicians, but also students from this country who have attended unaccredited foreign medical schools, and returned here to be added to the practice pool.

At present there may be as many as 20,000 U.S. citizens attending medical school abroad. Most of them are enrolled in the so-called "offshore schools" of the Caribbean, which are neither accredited nor approved by any of the usual authorities. Many of these schools are little more than diploma mills. They offer a degree which has no credibility in the medical community, and which is honored only to the extent that these physicians are allowed to return to this country and sit for medical practice licensure examinations. This occurs predominantly in New York state, where licensure laws are extremely permissive regarding foreign medical graduates, but it is also a problem elsewhere in the nation.

Several thousand physicians a year are thus entering the practice pool in addition to the seventeen thousand that we graduate from our own schools. This further complicates the problem of the oversupply of physicians.

A rational exploration of this situation would suggest that if we are to have more physicians than we need, we certainly should have more physicians who are qualified, not an abundance of physicians who are not qualified by virtue of an inferior medical education.

We are at a crossroads in medical education. The costs are staggering to the public. They must be borne in part through tax dollars, because health care is a national resource. This being the case, all of us — public servants, medical educators, and licensing authorities -- have a public obligation to make every effort to improve the quality of our practicing physicians. Instead, we are diluting it by bringing into our health care delivery system physicians who are ill-trained to meet the challenges of providing the best medical care in the coming decades.

How should we go about fulfilling this obligation? There is no federally mandated licensure requirement for the practice of medicine, and no federal controls are imposed on this process. The National Board of Medical Examiners is the most credible and creditable examining authority. It is not a federal authority but a private agency, supported by medical schools, by the candidates for examination themselves, and by various other licensing boards, since the National Board constructs many of the licensure examinations used by various state boards.

Not all states require licensure from the National Board of Medical Examiners for an individual to practice medicine. Some states have their own individual licensure examinations. In New York state, for example, the requirements for examination and licensure for physicians trained abroad — whether they be foreign-born or United States citizens — are established not, as one might perhaps expect, by the Commissioner of Health but rather by the Department of Education under the New York State Board of Regents. Other states have different sysystems. However, the mechanisms of regulation and medical licensure are often divorced from the medical education enterprise, and it is clear that the medical schools themselves cannot influence the licensing procedure. Medical educators have not yet been invited to participate in the licensing process, and the mechanics of how licensure for the graduates of foreign medical schools is handled thus lie outside the medical education system of this country.

Nonetheless, there are several mechanisms by which we could improve the quality of the practice of medicine, and ensure that any foreign-trained physician seeking licensure in this country would meet our standards. One approach would be to insist that any physician with a degree from a non-accredited offshore or other foreign medical school be required to complete a minimum of two years of additional education in an accredited U.S. medical school before being permitted to take any licensure examination. The two years would include one year of basic science studies and one year of clinical medicine.

Other means of control might include more rigid enforcement of licensure requirements. Serious consideration should also be given to requiring all foreign-trained physicians who do pass a licensure examination to undergo further training in approved residency programs, rather than simply in community hospitals as is now so often the case.

Finally, we could address the problem by more selective consideration of the known capability of the school from which the foreign-trained student has graduated. We know, for example, that only three percent of the graduates of certain of these schools are able to pass our licensure examinations. Based on that track record, it might be reasonable to determine that graduates of such an institution not be granted the privilege of taking the licensure examination.

All of these measures can and should be considered by responsible licensing authorities, in my opinion.

If we are in the posture of overproduction of physicians as I assert, and I firmly believe we are, then why not reduce the enrollment of our medical schools? Because we would be foolish to reduce enrollment across the board in the qualified, approved and accredited medical schools in this nation so long as we continue to see an influx of poorly prepared, poorly trained physicians from foreign, unapproved, unaccredited and incompetent schools of medicine that offer degrees of questionable value. Until and unless that influx is stemmed, our own schools would be ill-advised to make massive cuts in enrollment.

On the other hand, I would point out to the committee that some institutions of leadership and imagination have addressed this issue and are already reducing enrollment, several schools by significant percentages. Most recently, the Duke University School of Medicine announced that over the next four years it would reduce its medical student enrollment by ten percent. This is an innovative, imaginative move by a leading institution which can afford the loss of tuition that is generated by a reduction in the number of enrolled students.

Clearly, this sort of initiative invites emulation by other institutions, and I can tell you that we at Mount Sinai School of Medicine have considered similar moves. The deans of the medical schools of the state of New York are prepared to address the issue of reduction in enrollment. We represent thirteen schools, or approximately ten percent of the nation's medical educational capability, and we are prepared to act jointly in this matter, provided we can see some reduction in the influx of foreign-trained physicians who are inadequately trained to provide the level of medical care that we think is appropriate to the citizens of this country.

In closing, let me reaffirm my belief in the importance of supporting medical education as a national resource and the pressing need for both federal and state programs to provide scholarships and grants in aid for medical students. Without such aid, health care costs will only continue to soar as physicians attempt to pay off their mountainous educational debt by increasing their fees. Further, we will simply discourage many potential physicians, and studying medicine will become an option available only to the wealth. This is scarcely the hallmark of a democratic society.

National Association of Pediatric
Nurse Associates & Practitioners

TESTIMONY OF THE
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS
ON THE
NURSE TRAINING ACT OF 1984

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

March 1984

NAPNAP NATIONAL OFFICE: North Woodbury Road, Box 56 / Pitman, New Jersey 08071 / Telephone 609-589-5077

The National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) is pleased to present written testimony supporting the reauthorization of the Nurse Training (Education) Act of 1984. NAPNAP is available to work with the Committee on Labor and Human Resources in developing and passing reauthorization legislation pertaining to nurse practitioners and the Nurse Training (Education) Act.

NAPNAP is a formal professional organization that represents 2600 pediatric, family, and school nurse practitioners. NAPNAP has been instrumental in defining the Pediatric Nurse Practitioner (PNP), developing a Scope of Practice, developing Educational Guidelines, and developing and implementing a national certification and certification maintenance procedure. The organization is also active in supporting and conducting nurse practitioner research as well as disseminating the research findings. Primarily NAPNAP addresses PNP issues relevant to education, practice, certification, professional development and research.

Pediatric nurse practitioners were the first educated nurse practitioners and have been in existence for about 20 years. By definition, a nurse practitioner is a registered nurse who has completed an educational program preparing him/her to provide primary health care. The formalized educational program meets ANA/AAP Guidelines and the curriculum includes preparation in development of clinical judgment and decision-making based on a specific primary child health care core. Pediatric nurse practitioners in the future will be registered nurses with a minimum of baccalaureate nursing degrees and nurse practitioner education either in formal continuing education or master's programs.

The educational preparation enables the pediatric nurse practitioner to provide nursing care in primary health care settings in collaboration with other health care professionals. While most practice settings are ambulatory care facilities, the PNP may also contribute to the delivery and continuity of health care services within hospitals and other acute and long-term settings.

PNP's are synonomous with safe, cost-effective, and quality primary health care. For instance, the actual appointment "show" rates, return visits, and immunization levels of consumers are higher in nurse practitioner clinics than in non-nurse practitioner clinics. What is it that encourages consumers to seek or return for care from nurse practitioners? Quite simply -- their INDIVIDUAL needs are met through direct care, education, counseling, referral, etc. Cost-effectiveness and quality care has been well documented over the past five years. NP's have been credited with possessing detailed interviewing/communication skills which in themselves have been cost-effective by decreasing the needs for some laboratory tests and prescription medications. Since NP's are known to identify more signs and symptoms through detailed histories and physical exams, the cost-effectiveness is realized through early problem identification, resolution and prevention of further or future sequelae. Through early identification and resolution of health care concerns, consumers are spared unnecessary visits to the emergency room as well as unnecessary days away from school and work.

Cost-effectiveness touches the pockets of consumers, health care providers, insurance carriers, tax-payers, and the federal government. Cost-effectiveness of NP's in primary health care, health education, counseling and follow-up services has been well documented. Through follow-up care, consumers have reported a high level of satisfaction with nurse practitioner/consumer relationships.

Nurse practitioners are also concerned about their professional education and their competency of practice. This is reflected through NAPNAP members support of continuing education, certification and certification maintenance. Certification for PNP's is available through either the National Board of Pediatric Nurse Practitioners/Associates or the American Nurses' Association.

NAPNAP does support the concept of NP education occurring at the master's level. However, there must be some plan for financial support for those NP programs that have not yet been absorbed into the master's programs. It is much too costly to begin new educational programs when those that are in place can be assisted in meeting special needs of the nursing profession or becoming graduate programs in nursing.

Professional research expertise evolves from master's and doctoral preparation. There is a need for continued nurse practitioner research in educational and practice settings, but until nurse practitioners are master's and doctorally educated, nurse practitioner conducted research will remain sparse. Many of the existing research studies have been conducted by physicians or social scientists. Professionally, it is necessary for nurse practitioners to develop research studies to further document consumer benefits and the nurse practitioner contributions to the health care system.

The 1983 report by the Institute of Medicine, NURSING EDUCATION: PUBLIC POLICIES AND PRIVATE ACTIONS, stresses the need for the services of nurse practitioners and continued funding for advanced education for nurses. NAPNAP strongly urges the Committee on Labor and Human Resources and the Congress to pass a Nurse Training (Education) Act which strongly supports nurse practitioner education, practice, and research that will strengthen the health care system. Preparing health care providers that are safe and cost-effective in turn pass along quality and cost-effective effective care to the consumers.

Additionally, NAPNAP supports the Tri-Council recommendations for the Nurse Training (Education) Act; the increased authorization levels, for Advanced Nurse Training, Nurse Practitioners, Nurse-Midwifery Education, and Professional Nurse Traineeship programs. Again, if NAPNAP can be of assistance in developing this important legislation, please contact us.

Several publications about nurse practitioners have been included with this testimony. Thank you for your assistance in introducing this important legislation.

PUBLICATIONS

1. THE PEDIATRIC NURSE PRACTITIONER - The National Association of Pediatric Nurse Associates and Practitioners

2. SCOPE OF PRACTICE - The National Association of Pediatric Nurse Associates and Practitioners

3. PHILOSOPHY, CONCEPTUAL MODEL, TERMINAL COMPETENCIES FOR THE EDUCATION OF PEDIATRIC NURSE PRACTITIONERS - The Association of Faculties of Pediatric Nurse Associates/Practitioner Programs, Inc.

4. NURSE PRACTITIONERS: A REVIEW OF THE LITERATURE 1965-1982 - American Nurses' Association and National Association of Pediatric Nurse Associates and Practitioners

5. NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS/ NATIONAL BOARD OF PEDIATRIC NURSE PRACTITIONERS & ASSOCIATES

6. NAPNAP FOUNDATION - National Association of Pediatric Nurse Associates & Practitioners

7. COST-EFFECTIVENESS/QUALITY OF CARE (Nurse Practitioners) - Bibliography

Testimony of David Calkins, M.D., Chairman, Health Policy Committee, Society for Research and Education in Primary Care Internal Medicine, regarding the Health Professions Training Assistance Act of 1984.

Submitted for the record of the Committee on Labor and Human Resources, United States Senate.

March 26, 1984

I am pleased to have this opportunity to submit testimony on the Health Professions Training Assistance Act of 1984 on behalf of SREPCIM -- the Society for Research and Education in Primary Care Internal Medicine. SREPCIM was founded in 1978 as an affiliate of the American College of Physicians. Our major purpose is to promote the training of physicians in primary care or general internal medicine. Most of our members, who now number about 900, serve on medical school faculties, and many are involved in the teaching of residents in general internal medicine. Accordingly, SREPCIM is especially interested in that portion of the Health Professions Training Assistance Act which provides authority for training grants in general internal medicine and general pediatrics, and I will confine my remarks to that portion of the Act.

During the mid-1970's members of this Committee joined other leaders in government and medicine in calling for an expansion in the supply of primary care physicians. As a result medical schools and teaching hospitals began to develop divisions of general internal medicine within departments of medicine, and some established special training programs in primary care internal medicine. This process was accelerated greatly by passage of the Health Professions Education Assistance Act of 1976 (Public Law 94-484), which provided authority for training grants in general internal medicine and general pediatrics.

The central purpose of these training grants is the support of a new kind of residency training. Primary care internal medicine residency training differs from traditional internal medicine training in several important ways:

- More teaching occurs in an ambulatory setting. In a traditional internal medicine residency, about 10 percent of a resident's experience is in an ambulatory setting. In the primary care programs supported by federal training grants, more than 25 percent of training takes place in such settings. Thus, primary care residents are better prepared to care for their patients outside the hospital and therefore may be less likely to advise unnecessary and costly hospital admissions.

- Primary care programs emphasize continuity of care. Residents maintain responsibility for their patients over an extended period of time, serving as the patient's advocate in an increasingly complex health care system. They learn how to help patients use health care resources in an appropriate and efficient manner.

- Primary care residents acquire skills in areas such as psychiatry, dermatology, orthopedics, and office gynecology, which are not part of traditional internal medicine training. Thus, they are able to manage the vast majority of problems encountered in ambulatory adult patients without referrals to subspecialists.

- Residents are taught principles of health maintenance. They work with other health professionals, including nutritionists and nurse practitioners, to counsel patients regarding diet, exercise, and other health-related behaviors. Thus, primary care residents are able to help patients stay healthy as well as treat them when they are ill.

- Primary care training emphasizes cost-effective approaches to health care. Residents learn when to use laboratory tests as well as when not to use them. They also learn that there are alternatives to hospitals and nursing homes — and even physicians -- which may offer their patients more appropriate and less costly care.

- Perhaps most important, residents in these programs learn through experience and example that a career in primary care can be intellectually and personally rewarding - and they stay with it. Due in large measure to the impact of these training programs, the proportion of internal medicine residents electing subspecialty training dropped from 66 percent in 1976 to 53 percent in 1981. This will mean more primary care physicians and fewer subspecialists in the years ahead.

While the principal purpose of the training grants has been to support the education of primary care residents, they have had other desirable effects. They have been a major stimulus to the development of divisions of general internal medicine within departments of medicine throughout the United States. A 1979 survey of major teaching hospitals found that 77 percent had divisions of general internal medicine. Nearly half of these units had been created since 1976. The general internists who staff these divisions play a critical role within their departments:

- Faculty in divisions of general internal medicine spend almost half their time in direct patient care, usually in hospital-based clinics or group practices. These clinics are an important source of ambulatory care, especially for the poor. The presence of full-time faculty in such clinics has led to improvements in both the quality and efficiency of services.

- Faculty in divisions of general internal medicine spend about a third of their time teaching in ambulatory and inpatient settings. They supervise residents in traditional internal medicine programs as well as those in primary care. General medicine faculty play an important role within traditional internal medicine programs. Studies show that internal medicine subspecialists are often the principal source of care for their patients. If those graduates of traditional programs who become subspecialists are to be effective in the role of primary physician, they need to learn the skills of the general internist. This includes a knowledge of health promotion and disease prevention activities, as well as cost-effective approaches to health care.

- General internal medicine faculty serve as important role models for medical students, interns, and residents. Studies indicate that medical school faculty have a significant influence on the career choice of physicians in training. The dominant role model on most medical school faculties is the subspecialist. The academic general internist offers trainees, including those in traditional internal medicine programs, an alternative.

The development of general internal medicine residency training programs and faculty divisions of general internal medicine would not have been possible without federal grant support. Our current practices of paying physicians and hospitals encourage the development of faculties dominated by subspecialists and residency training programs focused on technology-intensive inpatient services. By explicitly funding ambulatory care teaching, the residency training grants have provided departments of medicine with an incentive to add to their ranks faculty interested in general medicine and residents whose training includes substantial ambulatory care. Continued funding of the residency training grants is critical to the maintenance of these activities. Therefore, we urge you to extend this program at the current authorization level, adjusted for inflation.

Further growth of residency training in general internal medicine and general pediatrics will require an expansion in the supply of medical school faculty trained in these disciplines. Fellowship programs in general internal medicine and general pediatrics can help meet this need. Although existing law authorizes support of such fellowships, the Department of Health and Human Services has to date allocated no funds for this purpose. We suggest therefore that in the report which accompanies this bill you make clear your intent that a portion of funds appropriated under this authority be used for fellowships in general internal medicine and general pediatrics.

Our nation faces many health care problems: a continued shortage of primary care physicians, an aging population in need of more chronic care, and spiraling costs for health care services. Primary care internal medicine can be a part of the solution to many of these problems. General internists can meet the demand for more primary care services in both urban and rural areas. They can evaluate the needs of the chronically ill elderly and supervise their care at home or in an institution. And they can act as a broker for the patient in an increasingly technology-oriented health care system, assuring that care is provided in a cost-effective manner. The federal investment in primary care internal medicine training is sound. Sustained federal support is essential to the maintenance of this training effort.

Thank you again for this opportunity to present our views.

WRITTEN STATEMENT
OF THE
SOCIETY OF TEACHERS OF FAMILY MEDICINE

Submitted to the Senate Committee on Labor and Human Resources

Re: Health Professions Reauthorization Legislation

The Society of Teachers of Family Medicine represents 2,400 faculty in 115 departments and divisions of family medicine in U.S. medical schools as well as faculty in 388 family medicine residency programs in hospitals across the United States. We appreciate the opportunity to comment on reauthorization of Sections 780 and 786 of the Public Health Service Act which authorizes support of training programs in family practice.

Family medicine as a specialty of medicine has arisen over the past decade and a half as a result of societal need. The rise of specialization in medicine in the 1940s, '50s, and '60s was associated with a concommitant decrease in numbers of general practitioners. Virtually all medical school graduates entered other specialties and general practitioners aged and retired.

This decrease in general practitioners resulted in a general shortage of primary care physicians as well as a progressive decline in the total numbers of physicians in rural areas. What was needed were specialist physicians educated in breadth who were qualified to coordinate the care of families and to handle the vast majority of common medical problems of individuals of all ages.

Federal assistance in development and maintenance of family medicine programs through Sections 780 and 786 has proven to be a powerful catalyst in development of family medicine training programs. Divisions and departments of family medicine within our nation's medical schools were virtually nonexistent in 1970. Today in most of our medical schools they provide much needed educational programs. Faculty serve as role models for medical students at the time they are selecting their specialty so today 12% of all medical school graduates enter family medicine. Three year residency training programs in family medicine, also practically nonexistent in 1970, today enroll over 7,400 physician trainees. Medical students graduating from medical schools which have received federal family medicine support enter family medicine at twice the rate of those from schools not receiving this support.

Graduates of family medicine programs are fulfilling our expectations. They are assisting in meeting primary care needs in every part of this country. With their indepth training in the specialty of family medicine, they are bringing a constellation of skills to their practices not previously included in residency training. Further, they are assisting in addressing problems of geographic distribution of physicians. Over 40% of family medicine residency graduates are practicing in rural (non-SMSA) counties. Only 13% of M.D.s nationally practice in these rural counties in which one quarter of the U.S. population resides.

We are proud of the accomplishments of our family medicine programs. However, continuation and enhancement of federal support for family medicine education under Sections 780 and 786 are essential if the gains of the '70s are to be maintained in the '80s.[4] Our nation will be well served by placing more of its graduates in family medicine with its focus on ambulatory care, AND PREVENTIVE CARE. WE ANTICIPATE THAT RURAL NEEDS FOR PHYSICIANS WILL CONTINUE BECAUSE RURAL PHYSICIANS ARE SIGNIFICANTLY OLDER THAN THEIR URBAN COLLEAGUES AND, CONSEQUENTLY, THEIR ATTRITION RATE WILL BE HIGH. THE FAMILY PHYSICIAN WILL CONTINUE TO BE THE PHYSICIAN MOST LIKELY TO SELECT RURAL PRACTICE.

GRADUATE MEDICAL EDUCATION IN THE U.S. IS FUNDED LARGELY FROM PATIENT CARE INCOME DERIVED FROM THIRD PARTY REIMBURSEMENT. A NUMBER OF STUDIES, HOWEVER, HAVE DOCUMENTED THAT FAMILY MEDICINE RESIDENCY PROGRAMS CANNOT FUND THE COSTS OF THEIR PROGRAMS FROM PATIENT CARE BECAUSE THEY ARE ORIENTED TO LOW INCOME GENERATING AMBULATORY CARE RATHER THAN INPATIENT HOSPITAL CARE. CONSEQUENTLY, TEACHING HOSPITALS GENERALLY ARE SUBIDIZING THESE RESIDENCIES.

EDUCATION OF FAMILY PHYSICIANS AND OTHER PRIMARY CARE PHYSICIANS WILL CONTINUE TO BE AN ESSENTIAL SOCIETAL NEED. UNFORTUNATELY HOWEVER, THESE PROGRAMS ARE NOT ESSENTIAL TO MOST OF OUR NATION'S TEACHING HOSPITALS WHICH TEND TO BE ORIENTED TO ADVANCED SECONDARY AND TERTIARY CARE. TODAY, HOSPITALS ARE approaching a crisis in the funding of graduate medical education. Increasing competition as well as progressive concerns about the long term support of graduate medical education through Medicare are forcing hospitals to reassess their commitment to graduate medical education. Incentives must be provided for hospitals to continue to maintain family medicine programs. Continued federal financial assistance of family medicine residencies through Section 786 will assist in providing these incentives.

Continued support of medical school departments, predoctoral programs, and faculty development in family medicine is also essential. Family medicine departments tend to be small and overextended. The shortage of qualified faculty is great. Despite their small size, departments of family medicine have been extraordinarily successful in creating a medical school milieu which fosters selection of family medicine as a specialty by their graduates.

The Society of Teachers of Family Medicine believes that the relatively small federal investment in the development of family medicine, medical school, and residency training programs has yielded rich dividends for the American people. It is essential that this investment be maintained and enhanced to permit increased dividends in the 1980s. We strongly recommend that authorization levels for Section 780 be maintained and that authorizations for Section 786 be increased to reflect inflationary losses of recent years. Recommendation No. 29 of the Report of the Graduate Medical Education National Advisory Committee (GMENAC) stated that, "Family practice programs, at least for the near future, should be given special attention in view of the difficulty in financing training programs from ambulatory care revenues." This statement is as true today as it was in 1980 at the time of its writing.

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April 10, 1984

Primary care training for general internists and general pediatricians has been supported by Section 784 of the Public Health Service Act since 1977. This program has been supported in order to redress the national imbalance of both medical specialties and geographic maldistribution of physicians. The program has been highly successful. It has provided support for residency training in general internal medicine and general pediatrics in all parts of the country. In 1983 there were 1,172 resident physicians training in a total of 55 programs which received support.

The impact of this federal training program reaches far beyond the individual physicians whom it trains. During the last six years, there has been a significant growth in the development of general as opposed to subspecialty medical training as a result of this program. Before 1970, less than 5% of the nation's teaching hospitals had Divisions or Sections of General Internal Medicine. Primary Care was not included in the standard curriculum for general internists, and did not receive special support in the training of general pediatricians. By 1979, with the support of the U.S. Public Health Service Act, Divisions or Sections of General Internal Medicine had become established in seventy-seven percent of the nation's medical schools. By 1984, the number of actual Divisions had almost doubled from 79 (1979) to over 140 (see accompanying map).

Sections of General Internal Medicine provide teaching faculty in every state which has a medical school or major teaching hospital. These faculty are engaged in the training of medical resident physicians and medical students.

The outcomes of Primary Care training are exemplified by a recent survey of the graduates of the Boston City Hospital's Medical Residency Training Program. This training program has two tracks, a primary care track, which has received federal support, and a traditional subspecialty-oriented track. A comparison has been made of the 51 graduates of the Primary Care Training Program and the 141 graduates of the traditional residency. This comparison reveals the following:

1. 80% of Primary Care Training Program graduates entered primary care careers, as compared to 34% of traditional pathway graduates from the BCH Department of Medicine Program.

2. Physicians who train at the Boston City Hospital and enter practice are likely to remain in urban centers (55-60% in both pathways). Primary Care graduates are twice as likely (18% vs. 9%) to practice in small town or rural areas. A full 65% of Primary Care Training Program graduates in practice are serving low income/high need groups whereas less than 35% of traditional graduates are doing so.

3. Primary care graduates in practice are more than three times as likely (46% vs. 13%) to practice with nurse practitioners as are traditional graduates. They are more likely to utilize social service agencies, more likely to use patient education resources, and are far more likely to be involved in cost-containment programs at their practice site.

4. 60% of Primary Care Training Program graduates provide medical care to school aged children or adolescents, compared to 15% of traditional graduates.

5. When asked what changes they would suggest in the Department of Medicine based on their current perspective, 35% of traditional graduates suggested greater emphasis on elements of the Primary Care curriculum.

Primary Care physicians are actively practicing both in community hospitals and in community office practices. By dividing their time between these two settings for medical care, they have an excellent opportunity to serve as patient advocates and cost-containers. These physicians are not dependent on, nor are they reimbursed for, any lucrative subspecialty procedures or tests. The career survey reveals that Primary Care graduates are far more likely to be involved in cost-containment programs in their office practices and community hospitals than graduates of the subspecialty medical track.

We request that funding be continued at the level of the 1984 appropriations of $17.5 million. Support for Faculty Development as described by the Society for Research and Education in Primary Care Internal Medicine is also requested in the amount of $2.2 million.

1985 Appropriation Request for Primary Care General Medicine and Pediatrics

17.8 million -- Residency Training
2.2 million -- Fellowship Support
20.0 million -- Total

Primary care internal medicine and pediatrics do not have extensive alternative sources of support. Comparisons with family practice reveal that in family medicine there is special federal support not only for residency training, but also support for faculty development and for the development of Departments of Family Medicine. Family Medicine Departments also receive substantial support from state legislatures. Family practice training programs are frequently located in smaller community hospitals which do not carry the administrative cost of programs based in larger teaching hospitals. These training programs also do not have access to the extensive educational resources of larger teaching hospitals. Therefore, the need for continued federal support for residency training in general internal medicine and general pediatrics is real, and is a different need than the continued need for support which also exists for the family practice programs across the country.

John Noble, M.D.
Professor of Medicine and Chief,
Section of General Internal Medicine

125 of the approximately 140 Divisions of General Internal Medicine are listed below. This information was compiled from preliminary results of a 1984 survey of all U.S. General Internal Medicine Divisions.

ALABAMA
  Birmingham
  Mobile

ARIZONA
  Tuscon

ARKANSAS
  Little Rock

CALIFORNIA
  Davis
  Orange
  La Hoya
  San Francisco (3)
  Loma Linda
  Stanford
  Long Beach
  Los Angeles

COLORADO
  Denver

CONNECTICUT
  Farmington
  New Haven

DISTRICT OF COLUMBIA
  Washington, D.C. (3)

FLORIDA
  Gainesville
  Miami
  Tampa

GEORGIA
  Atlanta
  Augusta

HAWAII
  Honolulu

ILLINOIS
  North Chicago
  Chicago (2)
  Maywood

INDIANA
  Indianapolis

KANSAS
  Kansas City

KENTUCKY
  Lexington
  Louisville

LOUISIANA
  Shreveport
  New Orleans

MARYLAND
  Baltimore (2)
  Bethesda (2)

MASSACHUSETTS
  Worcester
  Boston/Cambridge (11)
  Springfield
MICHIGAN
  Ann Arbor
  Detroit
  East Lansing

MINNESOTA
  Rochester (2)

MISSISSIPPI
  Jackson

MISSOURI
  Columbia
  St. Louis
  Kansas City (2)

NEBRASKA
  Omaha (2)

NEVADA
  Reno

NEW HAMPSHIRE
  Hanover

NEW JERSEY
  East Orange
  Newark
  Piscataway

NEW MEXICO
  Albuquerque

NEW YORK
  Albany
  New York City (6)
  Valhalla
  Rochester (3)
  Syracuse
  Buffalo
  Stony Brook

NORTH CAROLINA
  Winston-Salem
  Durham
  Chapel Hill
  Greenville

NORTH DAKOTA
  Grand Fork

OHIO
  Cincinnati
  Toledo
  Rootstown
  Cleveland

OKLAHOMA
  Oklahoma City

OREGON
  Portland

PENNSYLVANIA
  Philadelphia (5)
  Hersey
  Pittsburg

RHODE ISLAND
  Providence

SOUTH CAROLINA
  Charleston
  Columbia

TENNESSEE
  Memphis
  Nashville

TEXAS
  Houston (2)
  Austin
  Dallas
  Galveston
  San Antonio

UTAH
  Salt Lake City

VERMONT
  Burlington

VIRGINIA
  Richmond (2)
  Charlottesville

WEST VIRGINIA
  Morgantown

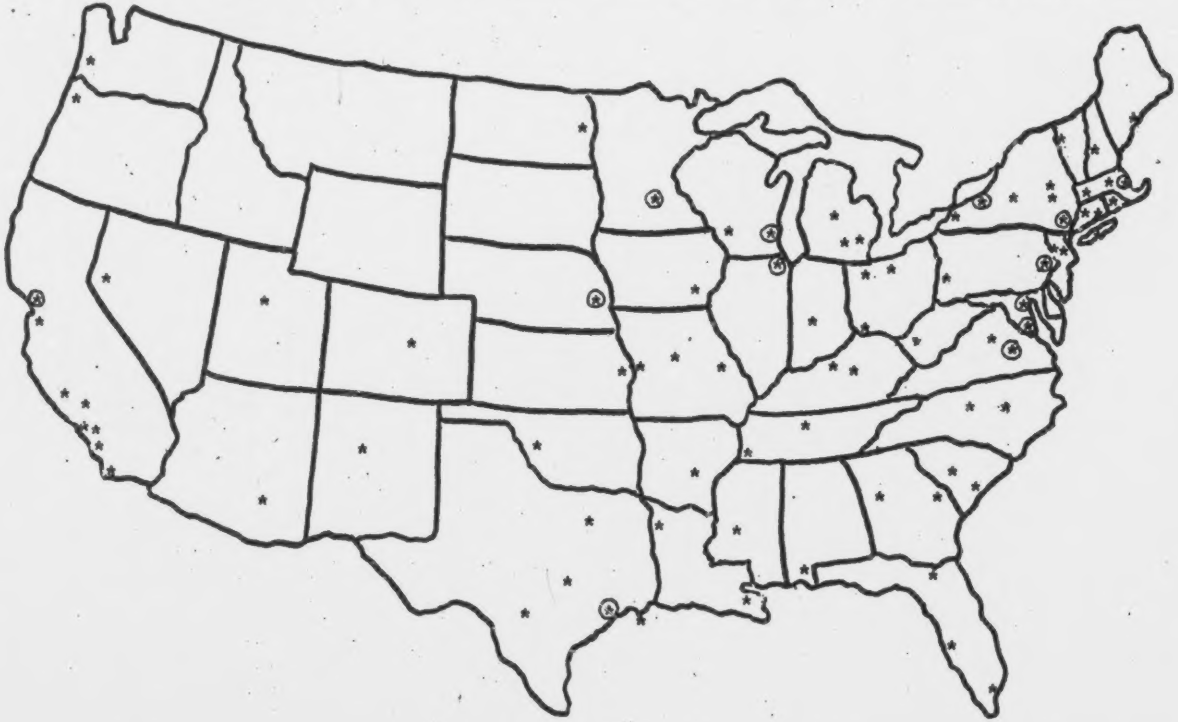
WISCONSIN
  Milwaukee (2)
  Madison
IOWA
  Iowa City

MAINE
  Portland

WASHINGTON
  Seattle

DIVISIONS OF GENERAL INTERNAL MEDICINE IN THE CONTINENTAL UNITED STATES

(Data Compiled from a Survey of the 140 Divisions of General Internal Medicine in the United States)



* = One Division of General Internal Medicine

⊛ = More than One Division of General Internal Medicine

AMERICAN COLLEGE OF NURSE-MIDWIVES

1522 K Street, N.W., Suite 1120, Washington, D.C. 20005 202/347-5445

TESTIMONY OF THE
AMERICAN COLLEGE OF NURSE-MIDWIVES
ON THE
NURSE TRAINING ACT OF 1984

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

MARCH 14, 1984

SUMMARY

Testimony of the
American College of Nurse-Midwives
on the
Nurse Training Act of 1984

Committee on Labor and Human Resources
United States Senate

March 14, 1984

- Nurse-midwifery care is particularly well-equipped to address two serious national health problems -- the persistently high rate of low birth weight and premature births and the rising cost of health care.

- Nurse-midwifery care has brought about dramatic reductions in infant mortality rates among women and infants who live in poverty. Nurse-midwifery care has also been found to be competitive and cost effective in the health care marketplace.

- Federal funding of nurse-midwifery education is critically important to the profession and stimulated a tripling of the number of certified nurse-midwives in the U.S. during the 1970s.

- The American College of Nurse-Midwives urges the Committee on Labor and Human Resources and the Congress to reauthorize the Nurse Training Act this year and to provide funding levels adequate for the challenge of educating sufficient numbers of nurses and nurse-midwives.

The American College of Nurse-Midwives (ACNM) is pleased to present testimony on the reauthorization of the Nurse Training Act. The College looks forward to working with the Committee on Labor and Human Resources on the development and passage of this important legislation.

Nurse-midwives have practiced in this country since 1925, almost 60 years. Throughout this time, nurse-midwives have worked extensively with women and families who live in poverty. In the early 1970s, affluent consumers discovered nurse-midwifery care. In response to this consumer demand, nurse-midwives began working in the private sector as well as the public sector.

The American College of Nurse-Midwives defines a certified nurse-midwife as "an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives." Nurse-midwifery practice is defined as the "independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically. This occurs within a health care system which provides for medical consultation, collaborative management, and referral and is in accord with the 'Functions, Standards and Qualifications for Nurse-Midwifery Practice' as defined by the ACNM."

The American College of Nurse-Midwives represents certified nurse-midwives in the United States and is an autonomous organization. The ACNM speaks for certified nurse-midwives on issues pertaining to the education, clinical practice and professional development of the profession.

Nurse-midwifery care is particularly well suited to addressing two of our most serious national health care problems, the persistent rate of low birth weight and premature births and the rapidly rising cost of health care. Nurse-midwifery care has been continuously scientifically scrutinized over the last 60 years and each study has shown that nurse-midwives provide safe care. In addition, all of the studies of nurse-midwifery practice in poor and sociologically at-risk populations show striking reductions in infant mortality and morbidity rates after the introduction of nurse-midwifery care. Federal studies issued in 1979 and 1980 by the Department of Health and Human Services, the General Accounting Office and the Graduate Medical Education National Advisory Committee have strongly recommended increased utilization of nurse-midwives in programs designed to provide care to poor families. The Institute of Medicine's 1983 report, "Nursing and Nursing Education: Public Policies and Private Actions," echoes these recommendations when it advises the federal government to contine funding for advanced education of nurses.

Although only one published study has looked at the link between nurse-midwifery care and cost savings achieved by virtue of improved infant outcomes, common sense dictates that healthy babies are less expensive babies. The research shows that nurse-midwifery care can make a crucial difference in birth outcomes in sociologically at-risk populations. Intensive care nursery care can easily cost $1000 a day; at that rate the government can spend in less than a month what it costs to educate a nurse-midwife.

Improved infant outcomes are not the only way that society reaps savings through nurse-midwifery care. Several characteristics of nurse-midwifery care lead to financial benefits for consumers and pubic or private payers. Nurse-midwives use expensive technologies, laboratory tests and drugs only when clinically indicated and not routinely. Consumers have requested and nurse-midwives have implemented programs which decrease or avoid use of hospitals, such as early discharge programs and free-standing birth centers. All of these characteristics can result in cost savings and increased competition in the health care marketplace. Nurse-midwifery care is now widely reimbursed, a condition which affirms the competitiveness and cost effectiveness of the profession's care. Many private and federal health insurance companies and self-insured employers have chosen to reimburse for nurse-midwifery care.

The federal government has mandated inclusion of nurse-midwifery care in CHAMPUS and Medicaid, and 14 state governments have mandated reimbursement by private insurance companies operating in that state.

Nurse-midwifery education began in this country in 1932 with one program at the Maternity Center Association in New York City. Twenty-eight institutions now offer nurse-midwifery education and all programs are affiliated with major universities. The quality of nurse-midwifery education is rigorously monitored by the Division of Accreditation of the American College of Nurse-Midwives through a regular schedule of education program self-assessment and review by experienced educators. The U.S. Department of Education has approved the Division as a national accrediting agency. The Division's activities insure that nurse-midwifery education programs are designed and conducted to produce clinically competent beginning practitioners. The Division has accredited programs housed in a variety of institutions, including schools of nursing, medicine, allied health and the U.S. Air Force. In nurse-midwifery certificate programs, students receive preparation for clinical practice. Master's and doctoral degree programs add additional courses in nursing theory, research, education and administration to the midwifery education.

The Division of Examiners of the ACNM maintains another quality control process for the profession. The Division administers a National Certification Examination which is open only to graduates of accredited nurse-midwifery education programs. The Division's activities have been recognized by the National Commission for Health Certifying Agencies as having met its highest standards for certification and testing procedures. Forty-three U.S. jurisdictions recognize ACNM certification as the primary credential necessary for practice in that jurisdiction.

Federal funding for education programs has been critical to the growth of nurse-midwifery. The number of nurse-midwives in the United States grew slowly from 1925, reaching approximately 600 by 1971. Over the next decade, the number more than tripled, growing to almost 1900. This rapid expansion is a direct result of significant support for nurse-midwifery education by the Division of Nursing and the Division (formerly Office) of Maternal and Child Health. The impact of the profession on the nation's health in the last decade can be judged in part from the quantity, as well as the contents, of numerous research studies reporting the impact of nurse-midwifery practice among poor populations during the 1970s.

The federal government began supporting nurse-midwifery education in 1960 with Title V funds administered by the Division of Maternal and Child Health; the Division has continued to support nurse-midwifery education and funded three in the 1982-1983 academic year. The Division of Nursing has funded nurse-midwifery education since 1972. During the 1982-1983 academic year federal funds allocated through the Divison of Nursing supported 17 of 26 nurse-midwifery education programs. Five of these programs received Advanced Nurse Training funds and 12 received Nurse Practitioner funds. During that year, the Division allocated a total of approximately $3,013,697 to nurse-midwifery education program support.

If the money not expended because nurse-midwifery care has kept infants from needing intensive care nurseries could be turned directly to nurse-midwifery education, the federal government would not need to provide any other means of supporting these education programs. That kind of creative accounting is, of course, not possible. It is obvious that investment in nurse-midwifery education, as well as placement of nurse-midwives in federal health care delivery programs, has been a wise use of government monies. A growing body of evidence suggests that nurse-midwifery care is competitive and cost effective in the health care marketplace. The clinical effectiveness and the cost effectiveness on nurse-midwifery care combine to make continued investment in nurse-midwifery education a wise decision by Congress and the executive agencies.

The American College of Nurse-Midwives urges the Committee on Labor and Human Resources and the Congress to pass a Nurse Training Act which will enable nurse-midwifery education to grow and to find innovative ways to achieve that growth. The College particularly supports increased authorization levels for the Advanced Nurse Training, Nurse Practitioner and Professional Nurse Traineeship programs. The College also supports the American Nurses' Association recommendations for the Special Projects programs and the addition of demonstration project authority for the Division of Nursing.

Where is nurse-midwifery taught?

Education Programs Accredited by the Division of Accreditation, ACNM current as of August 1983

Booth Maternity Center R
City Line and Overbrook Avenue
Philadelphia, PA 19131
(215) 878-7800, ext 600

Case Western Reserve *MB
Frances Payne Bolton School of Nursing
2121 Abington Road
Cleveland, OH 44106 (216) 368-2530

Columbia University Graduate Program in Maternity Nursing and Nurse Midwifery MB
Department of Nursing, Faculty of Medicine
Columbia Presbyterian Medical Center
622 West 168th Street
New York, NY 10032
(212) 694-3529, 5759

Emory University MB
Nell Hodgson Woodruff School of Nursing
Atlanta, GA 30322
(404) 329-6917

Frontier School of Midwifery and Family Nursing CB
Frontier Nursing Service
Hyden, KY 41749
(606) 672-2901

Georgetown University School of Nursing MB
Graduate Program Nurse-Midwifery
3700 Reservoir Road, N.W.
Washington, D.C. 20007
(202) 625-3559

Medical University of South Carolina CB
Nurse-Midwifery Program, College of Nursing
171 Ashley Avenue
Charleston, SC 29425
(803) 792-2000, 3093

Meharry Medical College CB
Nurse-Midwifery Program Dept. of Nursing Education
10005 D B Todd Blvd. Box 61-A
Nashville TN 37207
(615) 327-6494

Oregon Health Sciences University *MB
School of Nursing, Dept. of Family Nursing
Nurse-Midwifery Program
3181 SW Sam Jackson Park Road
Portland OR 97201
(503) 225-8382

Rush-Presbyterian-St. Lukes' Medical Center *D.N.Sc
600 S. Paulina Street
Chicago, Ill 60612 (312) 942-6604

St. Louis University MB
Department of Nursing
Graduate Program in Nurse-Midwifery
3525 Caroline Street
St. Louis, MO 63104
(314) 664-9800, ext 350/359

Stanford University *CB
Woman's Health Care Training Project
Primary Care Program
703 Welch Road, #F1
Palo Alto, CA 94304
(415) 497-6431

State University of New York CB
Downstate Medical Center
College of Health Related Professions
Nurse-Midwifery Program, Box 93
450 Clarkson Avenue
Brooklyn, NY 11203
(202) 270-1359 1360

United States Air Force (USAF) CB
Nurses only
Nurse-Midwifery Program
Malcom Grow USAF Medical Center
Andrews Air Force Base, MD 20331
(301) 981-6104

University of Arizona CB
College of Nursing, Nurse-Midwifery Program
Tucson, AZ 85721
(602) 626-7481, 6154

University of California at San Diego *MB
UCSF/UCSD Intercampus Graduate Studies
Family Nurse Practice
Nurse-Midwifery
University of California, San Diego, T-009
La Jolla, CA 92093
(619) 294-3685

University of California at San Francisco CB
San Francisco General Hospital
Room 6830
1001 Potrero Avenue
San Francisco, CA 94110
(415) 821-5106 or 647-7828

University of Colorado Health Sciences Center MB
School of Nursing Graduate Program
Nurse-Midwifery Tract
Box C 288
4200 East 9th Avenue
Denver, CO 80262
(303) 394-8654, 8061

University of Florida at Gainesville *MB
T Hillis Miller Health Center College of Nursing
P.O. Box J-187
Gainesville, FL 32610
(904) 392-3518

University of Illinois at the Medical Center MB
College of Nursing
Department of Maternal - Child Nursing
Nurse-Midwifery Program
P.O. Box 6998
Chicago, IL 60680
(312) 996-7937

University of Kentucky MB
College of Nursing
760 Rose Street
Lexington, KY 40536-0232
(606) 233-5406, 6620

University of Miami MB
School of Nursing
1540 Corniche
Coral Gables, FL 33124
(305) 284-3619

University of Minnesota MB
School of Nursing
5-140 Unit F
308 Harvard Street
Minneapolis, MN 55455
(612) 376-8472

University of Mississippi CB
Nurse-Midwifery Education Program
265 Woodland Hills Building
Jackson, MS 39216
(601) 987-4823

University of Medicine and Dentistry of New Jersey CB
School of Allied Health Professions
Nurse-Midwifery Program
100 Bergen Street
Newark, NJ 07103
(201) 456-4249, 4298

University of Pennsylvania MB
School of Nursing, Nursing Education Building
420 Service Drive, S2
Philadelphia, PA 19104
(215) 898-4335

University of Southern California CB
Nurse-Midwifery Program
Women's Hospital Room 8K5
1240 N. Mission Road
Los Angeles, CA 90033
(213) 226-3386

University of Utah MB
College of Nursing
Graduate Speciality in Nurse-Midwifery
25 South Medical Drive
Salt Lake City, UT 84112
(801) 581-8274

Yale University MB, CM
Maternal Newborn (Nurse-Midwifery) Program
855 Howard Avenue, Box 3333
New Haven, CT 06510
(203) 785-2423

CB -	Certificate Basic Program
MB -	Master's Basic Program
CM -	Combined RN/Master's Program
DNSc -	Doctoral Basic Program
R -	Refresher Program, only admits nurses who are registered in one of the 50 states, District of Columbia,/ or territories and must provide evidence of formal recognition as a midwife in the country or state of preparation.

* Pre-accreditation Status: a program initiating a nurse-midwifery curriculum which demonstrates its planning is within the guidelines established by the division to assure development of a quality education program. Programs are evaluated for accreditation status upon completion of the first class of students enrolled.

INTERNSHIP PROGRAMS (not approved by ACNM)

The internship program is an intensive advanced clinical experience designed for graduate nurse-midwives who have sat the ACNM National Certifying Examination. Internship programs do not require ACNM Accreditation. Internships may be arranged between the graduate nurse-midwife and the nurse-midwifery service.

Booth Maternity Center
City Line and Overbrook Avenue
Philadelphia, PA 19131
(215) 878-7800, ext. 600

Cleveland Metropolitan General Hospital
Nurse Midwifery Service
c/o Department of OB/GYN
3395 Scranton Road
Cleveland, OH 44109
(216) 459-4899, 5898

University of Miami
Jackson Memorial Hospital
Nurse-Midwifery Service 4C
1600 NW 12th Avenue
Miami, FL 33174
(305) 325-6984

University of Southern California
Nurse-Midwifery Program
Women's Hospital Room 8K5
1240 N. Mission Road
Los Angeles, CA 90033
(213) 226-3386

TESTIMONY
OF THE
AMERICAN NURSES' ASSOCIATION
ON
NURSING EDUCATION AND RESEARCH
BEFORE THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
ON
MARCH 14, 1984

The American Nurses' Association, on behalf of its 50 constituent states, representing 165,000 nurses, appreciates this opportunity to present our views on federal support of nursing education and research.

THE INSTITUTE OF MEDICINE STUDY

In March 1983, the Institute of Medicine of the National Academy of Sciences completed a two year study of nursing and nursing education. The study, contracted by the Department of Health and Human Services, was mandated by Public Law 96-76, the Nurse Training Act Amendments of 1979. The study was prompted by concerns as to whether further federal outlays for nursing education would be needed to assure an adequate supply of nurses. The intent of the congressional mandate was to secure an objective assessment of the need continued federal support of nursing education and research programs.

The American Nurses' Association commends the Institute of Medicine on its efforts to respond to its mandate from Congress, and is in general agreement with the conclusions of the study committee. With attempts by this and the past several administrations to drastically reduce the level of federal funding for nursing education, the recognition of the need for continued federal support by representatives from a variety of health related disciplines, academicians and other professions is significant. ANA views this recognition as advantageous to the profession as we move in concert with other health care professionals to address the critical issues in health care delivery before us. Further, we perceive the report as useful in bringing to the attention of Congress and the public many of nursing's concerns as well as priorities.

We agree with the IOM study's finding that current economic demands have created a temporary alleviation of the nurse shortage, and that this does not mean the shortage of nurses is over. Rather, as the committee has pointed out, shortages persist in certain geogrpahic areas, at particular health facilities, within specialties in nursing, and among those with advanced and specialized educational preparation and skills.

The costs of nursing education have risen rapidly over the past few years, and increases are projected to continue. Nursing students, who are predominantly women, finance their tuition and living costs from a combination of sources: the very limited funding remaining under the Nurse Training Act; general federal programs of financial aid; state and collegiate grant programs; earnings; and personal and family savings. Nursing education is facing a future in which resources will be more constrained than in the past. Nursing students tend to come from families with moderate incomes, or to count heavily on their own resources to finance their education. They bear the cost without the assurance of earnings comparable to those of students in other health-related fields who make similar educational investments. Continued reductions in assistance to schools and students could curtail the number of people entering the profession.

Thus, the American Nurses' Association embraces the IOM study's recommendations that the federal government should maintain financial aid to nursing students so that qualified prospective nursing students will continue to have the opportunity to enter nursing education programs in number sufficient to maintain the necessary aggregate supply, and to alleviate geographic and specialty shortages which continue to exist.

EDUCATION PROGRAMS UNDER THE NURSE TRAINING ACT

We believe it is obvious that federal involvement in nursing education has been an overwhelming success, and needs to be continued. Therefore, we endorse continuation of the following programs under Title VIII:

Advanced Nurse Training and Traineeships - The growing complexity of health care presents situations that increasingly require the specialized knowledge and experience of nurses with advanced nursing degrees. Also, the capability of those providing care at the bedside depend upon the skill and competency of their teachers, who must provide both the knowledge and clinical experience necessary to produce competent professionals. Regrettably, the nation's supply of nurses is short of persons who have been educationally prepared for advanced positions in nursing administration, nursing education, nursing research, and in clinical specialty areas.

At present, about 60,000 or less than 4 percent of all nurses are prepared at the masters or doctoral level. Only 62.5 percent of all full-time nursing facility members have masters degrees and only 5.3 percent hold doctorates. Less than half of nursing service administrators hold at least a baccalaureate degree; of this group, only 28 percent hold masters degrees. These individuals are responsible for over half of a hospital's budget and one-third of its personnel.

Registered nurses with quality graduate education are a scarce national resource, and the Congress should continue and strengthen federal support for such education. ANA agrees with the IOM study's recommendation that the federal government should expand its support of programs at the graduate level to assist in increasing the number of nurses with masters and doctoral degrees. The Advanced Nurse Training program under Section 821, the Traineeship program under Section 830 and the Nurse Anesthetist Traineeship programs under Section 831 should, therefore, receive increased authorization levels.

Special Projects - The Special Projects program provides grants and contracts to public and nonprofit institutions to develop innovative nursing methods emphasizing primary care and prevention to help meeting the needs of high-risk groups such as the elderly, children, and pregnant women.

The focus of the Special Projects program corresponds with a specific recommendation contained in the Institute of Medicine Report. The report recommends that the federal government offer grants to nursing education programs which, in association with the nursing services of hospitals and other health care providers, undertake to develop and implement collaborative educational, clinical, and/or research programs.

Priority areas addressed by the projects currently funded under this program include attracting minorities to the profession of nursing; providing nursing education outreach programs in geographically remote areas; and enhancing the work setting through cooperative arrangements between schools of nursing and hospitals. Current levels of funding for special projects have provided only for continuation of ongoing projects. Consequently, many worthwhile projects remained unfunded. The approved unfunded projects focus on training for nurses in the assessment and management of the elderly so that they can remain in their own homes; educating nurses in the care of high risk infants; providing access to educational opportunities in rural or inner city settings by extending established nursing programs via satellite campuses; providing upward mobility opportunities for licensed practical nurses to become registered nurses; and enhancing an institution's ability to retain nurses in practice.

Because the Special Projects program has, and can continue to, positively influence both clinical practice and nursing education, we request that funding be increased to a more adequate authorization level.

Nurse Practitioners - The majority of nurse practitioners serve in rural and inner-city communities, and focus their services on underserved populations such as migrant workers, low-income mothers and children, and the elderly. About half of the patients cared for by nurse practitioners have annual incomes of less than $4,000. A study by the Office of Technology Assessment on the cost effectiveness of nurse practitioners showed that their use results in productivity gains and cost reductions.

The 1982 Third Report to the Congress on the Nurse Training Act recommended extension of the nurse practitioner training program to meet the dictates of a redirected national health strategy emphasizing the promotion of health and prevention of disease, thus reducing the need for institutional care. The Institute of Medicine Report also cited a particular need for the services of nurse practitioners in medically underserved areas and in programs caring for the elderly.

ANA endorses the continuation of and increased funding for the Nurse Practitioner program. We also believe that special consideration within that program should be given to increasing the number of nurse-midwives, who contribute greatly to improved maternal and infant health in medically underserved regions of the country.

Student Loans - The Nursing Student Loan program provides low interest loans to undergraduate and graduate nursing students. Reports indicate that about two-thirds of loan recipients are from low-income families. According to a survey by the National Student Nurses' Association, 71 percent of those students receiving aid stated that they could not continue school without this assistance. Reduction in other higher education student assistance programs such as Pell Grants, Guaranteed Student Loans, and National Direct Student Loans will leave nursing students with few alternatives and permit only those from wealthier families to attend nursing school full-time.

Although the overall shortage of generalist nurses has been somewhat alleviated over the past few years, we believe that the current supply situation is clouded by economic conditions which have brought a decline in the demand for health services. However, the need still exists for financial assistance to those who lack access to nursing services and dollars to pay for them. Improved conditions could release a pent-up demand which would again trigger a shortage if care is not taken to maintain nursing supply at a high level. We are pleased that the IOM Report recommends the need for continued federal aid to assure that the nursing supply is maintained.

We are extremely concerned about proposed NSL regulations from the Department of Health and Human Services. Their proposal refuses to recognize the economic situations faced by most nursing students. While the Department admits that poor management of the program is more to blame than an unwillingness to repay by borrowers, future nursing students will bear the burden of the regulations. We ask that the proposed rules be redrafted to allow schools to continue to participate in the program so long as their current loan collection practices are in compliance with current NSL collection regulations, and schools are making good faith efforts to reduce prior delinquency rates.

Additional Programs - In addition to maintaining and expanding these existing programs, we would like to suggest the creation of two new programs within Title VIII. First, we would like to see a demonstration project authority, which would provide grants to schools of nursing and other entities for projects to establish nursing education/practice collaborations, to improve access to nursing services in the community, and to improve geographic and specialty distribution of nursing manpower. Second, we would propose a fellowship authority, which would provide a specific nursing fellowship program for full-time doctoral students, since the number of part-time students has increased markedly because of the paucity of funding for full-time study. The addition of these programs to the current law would greatly enhance our ability to produce qualified nursing leaders; and would gain valuable data regarding the increased use of cost-effective nursing care.

In summation: ANA believes that Title VIII should be funded at approximately the same level suggested in the IOM study, which would be an appropriation of approximately $80 million. Without such a reasonable funding level, the nation will be unable to expand the number of nurses with skills commensurate with the growing complexity of care in many health settings. We request that the Committee give serious consideration to an increased authorization level that would continue the federal government's commitment to a strong, qualified cadre of professional nurses.

NURSING RESEARCH

Nursing research addresses human and behavioral questions that arise in the treatment of disease, prevention of illness, and maintenance of health. Some of the human questions investigated are: how are individuals helped to assess their own health status and use existing resources to maintain health?; how are people helped to cope with their human responses to illness?; how are complications for hospitalized or critically ill individuals reduced?; how is illenss prevented for people who are highly subject to health risks such as premature infants or the elderly?; and, what are ways to measure anxiety, pain, and stress for people in hospitals and those with health problems?

Nursing research projects and grants have been funded in areas such as: maximizing the living skills of elderly nursing home patients; comprehensive nursing care for cancer patients; home care for children with cancer; cultural factors in hypertension; and helping patients with families with heart problems cope with stress associated with their hospitalization and rehabilitation. Research projects are authorized under Section 301 of the Public Health Service Act with an open-ended authorization. Research fellowships provide grants to institutions in support of predoctoral and postdoctoral fellowships, and are authorized under Section 472 of the Public Health Service Act.

Therefore, nursing research addresses the national need for focusing on cost effectiveness of quality health care services, and nurses are in a unique position to conduct such research.

Other factors also argue for an increased role for nursing research:

First, nursing research projects address important questions regarding patient care and have long-range implications for cost effective delivery of health care. The majority of nursing research projects currently funded by HRSA focus on nursing care of high risk populations, such as the elderly, premature newborns, the chronically ill, the disabled, and the dying. Second, last year, the United States spend over $300 billion, or 10.5% of the Gross National Product, on health care. A large proportion of this money is spent on nursing care, yet a limited federal investment is made in research efforts to improve the quality of this care. While approximately $4 billion is spent on biomedical research, less than $2 million of this amount was awarded to nursing research from all existing institutes within NIH. Third, support for nursing research is dependent to a large extent on federal funds. And finally, though expanding in recent years, the nursing research field is still very small, with only ,000 nurses prepared to conduct competitive research. As reported in the Third Report to Congress on the Nurse Training Act (1982), there will be a need for as many as 23,000 doctorally prepared nurses by 1990. The report also states that doctorally prepared nurses are a small but important cadre within the nursing profession, providing key leadership in the improvement of nursing practice, in the development of programs of nursing education, and in the design of innovative health care delivery systems.

It is important to note that the Institute of Medicine study also expressed strong reservations about the underfunding of nursing research. While a substantial share of the health care dollar is expended on nursing care, there is a remarkable dearth of research in nursing practice. The IOM report found the federal government's nursing research initiative not at a level of visibility and scientific prestige to encourage scientifically oriented RNs to purse careers devoted to research into the issues and problems that nurses confront.

In reviewing the recommendations of the IOM for building a strong research base for nursing, we conclude that the only place for a viable nursing research program would be an Institute of Nursing within NIH. Such an entity would be a focal point for promoting the growth of quality nursing research, and would provide an expanded pool of experienced nurse researchers needed to further develop the knowledge base for nursing practice.

It is not only nursing research that has been neglected. The health research enterprise of the federal government is almost exclusively directed toward basic biomedicine, clinical medicine, and pharmacological research. Entire fields have been pushed aside by NIH and the University Biomedic Science establishment. Largely passed over has been the behavioral science, nursing science, health promotion and rehabilitation medicine.

For example, the federal research enterprise is out of touch with developments and needs in the field of long-term care. Without a more balanced research agenda on the part of the national governmental agencies and universities, the results could be tragic by the end of this decade. A more substantial research base is required to develop regimes and systems that can result in quality, cost effective care for the nation's aged and chronically ill. Helping the nation redirect its goals and dollar allocations for health research is surely a legitimate responsibility of this committee.

We are pleased that the House of Representatives passed an amendment to H.R. 2350 creating a National Institute of Nursing. We are also pleased that Dr. James Wyngaarden, Director of NIH, has recently stated that he will establish a special task force regarding nursing research at NIH. While this is a positive step, we believe that legislation may still be necessary, and request that the Committee seriously consider supporting the concept of a Nursing Institute at NIH.

CONCLUSION

The federal government has made a significant and substantial contribution to nursing education and research. We ask this Committee to maintain that commitment to quality nursing and health care.

STATEMENT OF THE
AMERICAN ASSOCIATION OF COLLEGES OF NURSING

ON

FEDERAL SUPPORT FOR
NURSING EDUCATION AND
NURSING RESEARCH

TO

THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE

March 14, 1984

aacn
American Association of Colleges of Nursing
Eleven Dupont Circle • Suite 430 • Washington, D.C. 20036 • (202) 332-1917, 1918

The American Association of Colleges of Nursing (AACN) represents 356 college and university schools of nursing and approximately 8,000 full-time faculty. In serving the public interest, our organization exists to improve the practice of professional nursing through advancing the quality of baccalaureate and graduate programs; promoting research; and developing academic leaders. The AACN provides baccalaureate and higher degree programs in nursing with a framework through which issues critical to nursing can be considered and expeditiously acted upon.

We appreciate the opportunity to submit testimony to this committee on the reauthorization of Title VIII (Nurse Training Act) of the U.S. Public Health Service Act and on the support for nursing research on the Federal level. Our recommendations are based largely on the findings and recommendations of a two-year study of nursing and nursing education conducted by the Institute of Medicine (IOM). The Congressional mandate for this study was to secure an objective assessment of the need for continued federal support of nursing education.

The intent of the Nurse Training Act which was originally authorized in 1965 was two-fold: to expand the supply of nurses, and, to improve the quality and distribution of nursing services provided to the public. Over the past 19 years, the basic nursing supply problem has been addressed; however, the second Congressional charge to improve quality and distribution of nursing services has not received enough attention.

It is time to focus on the issues of quality nursing services and adequate distribution of those services. We are now at a point in health policy where there is a critical need for nurses who are educationally prepared to deliver high quality, complex services, to organize and administer those services in the most cost effective manner possible, to research the outcomes and effectiveness of nursing services, and, to prepare the nursing educators. The AACN believes that continual federal support graduate and baccalaureate preparation for nurses is essential to address these needs.

Institutional Support

Advanced Nurse Training. The IOM study emphasized the need for Federal pport for advanced nurse education and stated:

> The committee believes that RNs with high quality graduate education are a scarce national resource and that their education merits continued federal support (page 10).

ıe committee further determined:

> . . . a wide range of problems can be alleviated only by increasing substantially the supply of nurses with advanced education. The nation's cadre of professional nurses is short of persons who have been educationally prepared for advanced positions in the administration of nursing services and nursing education programs, in education (including research) and in clinical specialty areas (page 9).

Nursing can be instrumental both in reducing health care costs and providing quality health care services. However, this can occur only if schools of nursing are encouraged to develop and maintain graduate programs which will produce enough well-prepared nurse administrators, nurse educators, nurse clinicians and nurse researchers.

The scarcity of nurse administrators with advanced education is attested to by the National Survey of Registered Nurses in 1980 that reported that among the more than 61,000 RNs who occupied top nursing administrative positions, only 18% held a Master's degree and only 1.4% held a doctorate. Yet these nursing directors are responsible for departments that comprise about 30% of the total hospital budget. The focus on cost containment and the change to a prospective payment system in our hospitals increases the need for nursing administrators with advanced nursing education that includes business administration, economics, budgetary management, and human resources management in addition to advanced clinical practive. The IOM study found widespread conviction among administrators of hospital and long-term care facilities that their nurse administrator colleagues could make the delivery of care more cost effective if they had better grounding in financial management and in human resource management. Nursing service administrators should be equipped with the same academic preparation as their colleagues in other departments. Many Masters and Doctoral level nursing programs must revise their curriculums and expand their programs to speak to the evolving needs for nursing administrators. However, Masters and Doctoral nursing programs cannot be expanded and cannot meet the critical shortage of adequately prepared nurse administrators unless there is an increase in Federal support for the programs.

Nursing programs must also receive increased Federal support to meet the critical need for more nurse educators. This was particularly emphasized in the IOM study:

> Although the demand for highly qualified nursing administrators, faculty members, researchers, and clinical specialists prepared at the graduate level has been increasing and is expected to continue to increase, the evidence of a scarcity of nurse educators is most apparent (page 10).

Indications of scarcity of nurse educators are suggested by the fact that of the approximately 20,000 full-time faculty in all levels of nursing education in 1980, only 68% had a master's degree and only 7% held a doctoral degree. Among AACN schools 24% of the faculty held a doctorate degree. The proportion of nursing faculty with doctorates does not compare favorably with other disciplines. According to the Association of Schools of Public Health, well over one-half of the faculty employed by 20 schools of public health held at least one doctorate. Compared with science faculties, nurses showed up even more unfavorably. A National Science Foundation study of science and engineering faculty found that more than 90 percent held the doctoral degree. By comparison, in the 22 nursing schools having doctoral level programs in 1980-82, only 35 percent of the faculty in these institutions had doctoral preparation.

Additionally, constant changes in health care technology and advances in medical science have created extraordinary demands for the advanced degree nurse clinician who is able to provide direct patient services in acute care hospitals, community agencies and in long-term care settings. The IOM reported that the majority of university hospital administrators prefer masters prepared nurses for intensive care and other specialized patient units (p. 43). Patients are sicker, and there are many more technologies which sustain life and therefore require close monitoring. Patients on dialysis, respirators, and hyperalimentation are increasingly being cared for at home and have nursing care needs which were once strictly limited to inpatient, acute care settings. The complexity of long term care has increased dramatically, both in terms of numbers of patients as well as the intensity of services required by this population. The recently passed Medicare prospective payment system will further increase the demand for and complexity of services required in the community and long term care settings. To meet some of these needs, the IOM specifically recommended that Federal support be provided for instructional and clinical programs in all areas of geriatric nursing (page 14).

The estimates of future supply contrasts sharply with the estimates of needs for nurses with graduate degrees that DHHS projected for 1990. Using the judgment of need (WICHE) model, the projected minimum need for master's degree nurses was an estimated 256,000 and for doctorate degree nurses, it was an estimated 14,000. The IOM study projects that the supply of such nurses by 1990 would be considerably less than half those numbers (page 144). This prediction indicates an alarming shortage which represents a threat to our health care system.

State and local governments and the private sector simply cannot respond adequately or rapidly enough to address this critical shortage of nurse clinical specialists, nurse educators, researchers, consultants and administrators.

Therefore, a substantial increase in the Federal authorization is necessary to enable collegiate schools of nursing to plan, develop, operate, expand, and maintain programs for the advanced education of these nurses at the master's and doctoral level. This will enable schools of nursing to prepare the number and quality of graduate nurses that is necessary to meet our nation's needs.

Nurse Practitioner Programs. Included in this need for institutional support for advanced training is the need for increased Federal grants to collegiate schools of nursing for the education of nurse practitioners. The IOM study stressed the need for the services of nurse practitioners, expecially in medically underserved areas and in programs caring for the elderly and recommended that Federal support should be continued for their educational preparation.

Even with the anticipated increases in physician supply, nurse practitioners will be needed to serve hard-to-reach populations, to facilitate new organizational arrangements for providing health care in cost effective ways, especially in practice settings that operate within fixed budgets, and to augment the quality of care provided in nursing homes.

In a review of 15 studies, J.C. Record concluded in a 1979 DHEW document that between 75%-80% of adult primary care services and up to 90% of pediatric care services could be performed by nurse practitioners. Potential cost savings with the use of nurse practitioners was $0.5 billion to $1 billion or 19%-49% of total primary care provider costs. If we are to contain health care costs, the use of nurse practitioners to deliver high quality health care must be increased.

The trend for nurse practitioners to be educated in master's programs rather than certificate programs is supported by AACN. Since the nurse practitioner has a high degree of responsibility and autonomy, it is advantageous that they have advanced education in graduate nursing programs to prepare them for independent decision-making and provide them with a specialized in-depth knowledge base.

Nurse practitioner grants should continue to include current, well-established programs in nurse midwifery. The high quality and cost-effectiveness of nurse midwives are repeatedly demonstrated in research findings. For example, charges for nurse midwifery services at a New York Birthing Center are 37.6% of in-hospital care.

We recommend an increase in the authorization for grants to collegiate schools of nursing to plan, develop, operate, expand, or maintain programs for the education of nurse practitioners.

Special Projects. Grants to schools of nursing are necessary to increase opportunities for individuals from disadvantaged and ethnic-minority backgrounds to enter the nursing profession. Minority groups in the population, including new immigrants, are particularly disadvantaged both in their access to health services and in their access to educational opportunities in nursing. According to the IOM study:

> Strategies to develop minority manpower to provide more adequate nursing services in medically underserved areas have been stated as goals, though inadequately supported by past legislation. These goals require re-emphasis and new approaches through a redirection of authorization and funding available under the Nurse Training Act(page 13).

Special project grants are also needed to modify existing nursing education programs to provide opportunities for educational advancement, preceptor experiences, and for continuing education programs. The IOM study concluded that "Licensed nurses at all levels who wish to upgrade their education so as to enhance career opportunities should not encounter unwarranted barriers to admissions"(page 7). Schools of nursing need special project funding to develop programs to minimize loss of time and money by students moving from one nursing education program level to another. Advancement of diploma and associate degree graduates to the baccalaureate level is necessary for a period of time. This also will enlarge the pool for graduate level education. AACN supports an increased authorization for Federal grants to schools of nursing for special projects.

Demonstration Projects. There is a pressing need for demonstration models which improve collaboration between nursing education and nursing services. According to the IOM study:

> Closer collaboration between nurse educators and nurses who provide patient services is essential to give students an appropriate balance of academic and clinical practice perspectives and skills during their educational preparation. The Federal government should offer grants to nursing education programs that, in association with the nursing services of hospitals and other health care providers, undertake to develop and implement collaborative educational, clinical, and/or research programs (page 8).

Another type of demonstration project which is needed to improve patient care as well as to improve access to care, is the educational outreach program. Attesting to the need for such projects, the IOM study stated:

> To alleviate nursing shortages in medically underserved areas, their residents need better access to all types of nursing education, including outreach and off-campus programs. The Federal government should continue to co-sponsor model demonstrations of programs with states, foundations, and educational institutions, and should support the dissemination of results(page 11).

There should be no expectation that the nurse labor market will improve significantly in inner-city and rural area unless concerted actions are taken to develop an indigenous supply-- people who live in the shortage areas. Various forms of outreach programs can be designed to suit the requirements and convenience of students who, for reasons of family, residence, or the need to continue employment while studying, cannot readily attend existing campus programs. As well as improving the access to nursing services in the community, these projects will improve the geographic and specialty distribution of manpower.

Other types of demonstration projects include:

- Community Nursing Centers providing cost-effective care which would decrease hospitalizations and provide access to underserved populations.
- Demonstration projects of how patient teaching conducted by nurses in hospitals reduces the patients' length of stay and reduces readmissions. Under DRGs, some hospitals may attempt to cut costs by reducing the quantity and quality of nursing care. This will decrease patient teaching, increase complications, and prolong the length of stay. If patients are discharged early without adequate nursing care and teaching, they will have a high rate of complications and readmissions. Quality nursing care is the key to the success of the prospective payment system in hospitals and this needs to be demonstrated.
- Demonstration projects of how, in some cases, home nursing care is cost-effective substitute for hospital care. The projects should incorporate revisions in medicare policies such as "homebound status,""skilled care criterion," and "physician - established plan of care." It could be demonstrated that with certain revisions in current policies, the cost of care would be reduced and quality of care would be increased.

Student Support

Traineeships. To eliminate the critical shortage for nurses with advanced education, access to master's and doctoral level study on a full-time basis must be available to qualified individuals. Many RNs recognizing the need for advanced preparation do not have the resources to pursue full-time education. The IOM study stated that "Lowering financial barriers through loans and grants to encourage full-time enrollment of RN graduate students will increase the supply more rapidly, because master's and doctoral students who must work to support their education take longer to complete it"(page 10). Compared to other health professionals, nurses often do not have the earning potential to pay off large loans. Therefore, traineeships for the education of nurses are necessary to meet the need for more nurse educators, nurse administrators, nurse midwives, nurse anesthetists, and nurse practitioners. AACN therefore recommends that an increased reauthorization level should be made to support and increase in the traineeships for advanced education of nurses.

Fellowships. Pre and post doctoral fellowships granted on a competitive basis to nurses who are developing leadership abilities in areas such as primary care, administrative services, nursing research, and health policy specialities would promote further development of a cadre of nurse leaders. The development of a larger group of leaders in nursing is necessary for the nursing profession to contribute fully to the development of alternative health care modalities directed towards the containment of health care costs and the maintenance of quality services,

AACN recommends a new authorization to support an adequate number of pre and post doctoral fellowships for nurses.

Student Loans. The Deans represented by AACN support rigorous, but fair, nursing student loan (NSL) collection to ensure that government dollars under this program are protected and that this very worthwhile and essential program is continued. Much effort has been focused on this program in recent months and nursing schools have made dramatic improvements in loan collections.

However, in spite of these improvements,the proposed regulations for nursing student loan (NSL) programs,if enforced, would discontinue the program in 80% of all nursing schools. This would have a devastating effect on the nursing programs and would constitute a real threat to the supply of nurses. AACN members are confident that the intent of Congress would not be met by the proposed regulations and therefore we support statutory changes that would improve the NSL program and establish reasonable and achievable loan collection standards for nursing schools.

The original intent of the NSL program was to make loans available to nursing students who would be unable to meet commercial banking loan criteria. According to those criteria, nursing students are high risk borrowers. That is, most nursing students are only high school graduates, do not have a credit history, cannot post collateral, often come from moderate to low income families, and do not have the same earning potential as other health professionals, such as physicians. For this reason, the rigid application of commercial banking loan collection performance standards to this cohort of borrowers is ill-advised and is not consistent with the original intent of the program. In the same vein, applying the same regulations to the NSL grogram as are applied to the other health professions student loan (HPSL) programs is also questionable because the HPSL borrowers are college graduates and generally are a lower-risk cohort of borrowers.

We believe that schools must be allowed to continue as active participants in the NSL program as long as their current loan collection practices are in compliance with current NSL collection regulations, and schools are making good faith efforts to reduce delinquency on loans made prior to 1983. This could be achieved by providing the following provisions to the statute.

1. A school's compliance with current regulation shall be measured by a performance standard which is reasonable and achieveable for educational institutions.

2. School's administration and collection practices regarding loans made prior to 1983 shall not be reflected in the performance standard. A reporting system shall be devised to assure that schools undertake good faith efforts to collect old loans.

3. Regulations concerning administration of the NSL program (including 1 and 2 above) shall be developed using the notice and comment process and no school shall be suspended from active participation in the NSL program without a hearing on the record.

Preliminary findings in a survey of colleges of nursing who are members of our association indicate that a high percentage of the delinquency rates among the schools of nursing may be due to students who did not graduate from the nursing program. Expansion of the loan forgiveness provisions to assist schools in dealing with these loans is needed.

We recommend that when schools have made good faith efforts to collect delinquent loans but have been unsuccessful, they be allowed to assign or refer those loans to the government for collection. Since the school's best efforts are not always as persuasive as a letter from the Justice Department, allowing referral would be an effective tool to assist schools in pursuing delinquent borrowers.

When a school with an established NSL revolving fund closes, is suspended from the program, or cuts its class size significantly, all excess cash from the NSL program reverts to the United States Treasury. We recommend a statutory change which will allow such money to be re-programmed to other schools participating in the NSL program.

In addition to recommending a continuation of the revolving nursing student loan fund, we recommend a new authorization for the development of revolving funds in new schools of nursing or in schools that have not previously had a revolving fund. In this time of shrinking student resources, new schools and schools that previously did not have a need for the program ar now requesting to be included in the NSL program. It will not be possible for these schools to be included unless there is an adequate authorization.

General Authority for the Division

There is a need for the Division of Nursing to establish a program, including a uniform data reporting system, to collect, compile, and analyze data on professional nursing personnel. There is also a need to disseminate information from the Division of Nursing through publication, workshops and conferences. A general authority should be provided for the Division of nursing to accomplish these necessary functions.

Bureau of Nursing

AACN also strongly supports making the current Division of Nursing a Bureau within HRSA to increase the visability and support for nursing at the Federal level. We recommend that funds be authorized for start-up costs for such an entity.

Nursing Research

Over the past 15 years, various groups, such as the National Academy of Science (1977-80), the HEW Program Revëiw Committee (1968), and, most recently, the IOM report have consistently recommended increased Federal funding to encourage the growth and development of nursing research as a specific area of scientific inquiry. Although support of nursing research by scientific bodies has been consistent, the nursing research program housed in the Division of Nursing (HRSA) has not grown in funding and has remained at 1976 levels until FY84 when appropriations were increased to $9 million for nursing research grants. Funding for nursing research fellowships (NRSA) however, remained at $1 million.

Nursing research has been largely overshadowed by biomedical research which consumes the major share of the current $4 billion allocated to NIH.

Biomedical research focuses on the cure of disease and is perceived as priority research to the exclusion of other important types of research.

Nursing research, on the other hand, is the investigation of nursing care problems and provides the necessary scientific underpinning to the solution of those problems. The goal of nursing research is to facilitate the development of clinical nursing interventions which will improve health outcomes and contribute to the optimal delivery of care. The primary focus is on care as compared to other disciplines which focus primarily on cure. The nurse researcher starts with a care problem and then conducts studies related to that problem in the areas of basic biomedical sciences, the behavioral sciences, the clinical sciences, and health services research.

Although a substantial part of the health care dollar is expended on direct nursing care, a relatively small amount is invested in research efforts to improve the quality of nursing care. The significant increases in the cost of health care and the continued demand for quality health services has clearly demonstrated the critical need for research in cost-effective health care delivery systems, alternatives to institutionalization, improved outcomes for existing health care programs, and the prevention of health related problems. Nursing research has a tremendous potential for providing the basis to improve the quality and cost-effectiveness of health care services. However, this potential will be realized only if adequate funding and emphasis is providing for the nursing research effort. The IOM study recommended:

> The Federal government should establish an organizational entity to place nursing research in the mainstream of scientific investigation. An adequately funded focal point is needed at the national level to foster research that informs nursing and other health care practice and increases the potential for discovery and application of various means to improve patient outcomes.

In relation to the specific recommendations of the IOM, AACN was pleased that the House of Representatives passed an amendment to H.R. 2350 creating a National Institute of Nursing. We are also pleased that Dr. James Wyngaarden, Director of NIH, has recently stated that he will establish a special task force regarding nursing research at NIH. While this is a positive step, we believe that legislation may still be necessary, and request that the Committee seriously consider supporting the concept of a Nursing Institute at NIH.

We appreciate this opportunity to present our views on nursing education and research. THANK YOU!!

TESTIMONY

on

NURSING EDUCATON AND RESEARCH

submitted by

THE NATIONAL LEAGUE FOR NURSING

for

THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
Senator Orrin G. Hatch, Chairman

March 14, 1984

This testimony is submitted on behalf of the National League for Nursing, the organization which is nationally recognized as the official accrediting agency for nursing education. We are the largest American coalition of nurses, other health professionals, and consumers, dedicated to developing and improving the standards of quality nursing education, nursing services and health care delivery in the United States.

We appreciate the opportunity to present to this distinguished Committee our recommendations regarding the need for increased federal funding for nursing education. These funds are authorized under Title VIII of the Public Health Service Act, and are currently due for reauthorization for fiscal years 1985 through fiscal year 1987. Our testimony will also address the pressing need for greater emphasis on nursing research at the Federal level.

There can be no doubt that the complexity of today's health care settings demand nurses who are highly knowledgeable and skilled in many components of nursing and health care. New technology and treatment modalities require that nurses have more than just technical skills.

For instance, administering nursing care to a patient hospitalized with cancer can prolong life and improve the quality of that life. In a situation of this nature the patient is likely to receive as many as 5 chemotherapeutic agents, which must be administered with absolute accuracy, and with the knowledge of each drug's action and side effects. The patient's physical needs must also be met in terms of nutrition, mobility, skin care, hygiene, and susceptibility to other infections. The patient and his family also have psycho-social needs that must be considered - including the implication of dealing with a fatal illness and the effects of illness on the total family system. In addition, the patient (no matter what age or cultural background), needs education as to the meaning of the diagnosis, the treatments, and the prognosis.

It is the nurse who is responsible for most, if not all, of these services. As one physician author so aptly stated of nurses in hospitals:

> "One thing the nurses do is to hold the place (hospital) together. ...The institution is held together, glued together, enabled to function as an organism, by the nurses and by nobody else."[1]

The nurse also functions as the basic component in the delivery of health services outside of our hospitals and nursing homes, through home health care, community outreach programs, school nursing, public health nursing, and numerous other voluntary organizations. It is the nurse who, within all of these levels of care, is responsible for the communication and coordination between health professionals and the patient.

As the nation pays more attention to preventive medicine and diseases of the aged, there is a consensus among health planners that nurses can play an expanding role in the delivery of these services. The role of the nurse as a "patient educator" offers hope for our nation's health status through the day-to-day repatterning of behaviors toward healthier values and activities. The nurse is the only health care provider prepared with a knowledge base broad enough to encompass the entire range of activities and behaviors related to the health of the individual. What we currently have in this country is a system of health care geared toward acute episodic modes of treatment. What we need, because of changes in the demographic makeup of the nation and the nation's health status is a system geared toward prevention and chronic illness.

NURSING AND THE ELDERLY

Perhaps this role is of greatest consequence with regard to the elderly of this country. The number of persons age 65 and over increases by more than 500,000 each year. Today one out of every five people 85 years of age and older is a patient in a nursing home. By the year 2000 -- in 15 years -- this segment of the country's population will have increased almost five fold over what it was in 1960.

Along with demographic trends the growing emphasis in hospitals on early discharge (largely as a result of cost control and prospective payment) has resulted in mounting pressure to transfer patients with complex, multiple problems to nursing homes. This intensifies the need for more sophisticated nursing care. It also emphasizes the need for supportive services that can make it possible for more of these patients to be able to leave nursing homes and live at home. These trends will demand an increase in the kind of care nurses provide.

Our senior citizens rely primarily on nursing services, since extensive nursing care -- both institutional and home based -- is often the mainstay of their treatment regimes. This is especially true when one considers the large number of chronic illnesses which face society today, i.e. emphysema, diabetes, stroke, heart ailments and arthritis. Nurses with advanced training in areas such as gerontology, community health and rehabilitation can offer their expertise in settings as diverse as hospitals, hospices, HMOs, clinics, nursing homes, day care centers and at home -- all of which would improve quality of care for our nation's elderly. Not to provide advanced nurse training for educating these nurses would deprive the elderly of services for which they already are in dire need.

COST EFFECTIVENESS OF NURSING SERVICES

In this era of economic uncertainty and fiscal constraint, it is often overlooked that the nurse is the most cost-effective provider of care within our health care system. Through advantageous rate differentials, and cost-saving levels of health intervention, nursing is one of the basic cost containment tools available to our country. Research data are now available indicating that changes in nursing care can affect recovery rates, recidivism, and the success of preventive health measures. By varying the organization of care, nursing studies have demonstrated a 40 to 50 per cent reduction in the average length of stay of patients with abdominal surgery and renal transplants. In one study, the actual savings to the hospital for this population for one year was more than $51,000.[2]

With the implementation of prospective payment and the new look at services beyond the acute care settings, it is important to realize that nurses are the "backbone" of home health care agencies and skilled nursing facilities -- the two alternatives most frequently chosen in attempts to decrease utilization of more costly hospital resources. Nurses with graduate training are needed in these settings in order to deal with the complexity of the caseloads, the responsibilities of coordination and management, the budgetary considerations, and the need to provide quality care.

ADVANCED NURSE TRAINING

Despite the widely-held belief that the nursing shortage has abated, there are still serious categorical shortages of nurses and, perhaps the most serious problem of all is the dearth of nurses in leadership positions. Presently, there is a shortage of clinical specialists, teachers, and administrators for service agencies, educational institutions, and government. During the next decade, an increase in demand for these highly specialized workers is projected. For instance, according to the 1983 Institute of Medicine (IOM) study which was mandated by Congress, supply of nurses with advanced nurse training is not nearly enough to meet the growing need. By one estimate, 256,000 FTE masters level nurses would be needed by 1990, while supply of master's prepared nurses is predicted to reach only 112,400.[3]

Advanced medical technology has resulted in the need for more highly skilled nurses who are educated to provide leadership in patient care settings as diverse as infants in high risk nurseries and elderly patients in nursing homes. Clinical nurse specialists are being educated in advanced nurse training programs to assume the responsibility for developing a plan of care over a twenty-four hour period, demonstrating care to other nursing personnel, and providing health teaching and counseling to patients and families. Nurses now need skills such as computer proficiency and scientific and mathematical sophistication to adjust to rapidly changing technologies in hospital settings.

Among faculty teaching in all three types of programs which prepare registered nurses, only 65% are prepared at the minimal or master's level, with under 8% of all faculty having doctoral preparation.[4] Compared with other professions, this is a very low percentage of doctorally prepared educators.

Among directors of nursing services, a large proportion have only a basic diploma preparation. Only 25% have a baccalaureate degree and even fewer have graduate level preparation, yet these same individuals are responsible for large personnel budgets and significant policy decisions within health care agencies. The IOM report also found a "widespread conviction ... among administrators of hospitals and long-term care facilities that their nurse administrative colleagues could make delivery of care more cost effective if they had better grounding in financial management and other areas."[5]

NURSE PRACTITIONERS

In the primary care arena, nurse-practitioners have already shown that they can improve access to care for patients in urban and rural settings at a lower cost. By addressing the patient's psycho-social and educational needs, nurse-practitioners help patients adhere to prescribed regimens and repattern their behavior to healthy lifestyles. This in turn can reduce their use of more costly resources, such as frequent hospitalizations and emergency room visits.

Many studies have documented the cost benefits of using nurse-practitioners in primary care. A study at a Kaiser plan in California showed that when nurse-practitioners were employed, average cost per patient for a twelve month period was $98.63, in contrast to the $131.19 average for physicians.[6]

Another study reported that when school nurse-practitioners were employed in Arizona, the school district realized a savings of $19,000. This was achieved by eliminating the position of school physician and purchasing medical consultation services from the local university when needed.[7]

In order to privide quality cost effective health care, the preparation of nurse-practitioners is essential. Because of the high degree of autonomy which characterizes their practice, it is essential that nurse-practitioners have advanced education in graduate nursing programs to prepare them for independent decision making and provide them with a specialized, in-depth knowledge base.

Nurse-midwives have also demonstrated their ability to deliver safe, high quality, personalized maternity care which is also markedly less expensive than traditional hospital care. Charges for nurse-midwifery services at a New York City child bearing center were 37.6% of in-hospital care. An audit report noted that the cost to Blue Cross for families delivered at the Center is 66% of the cost of the plan had the same family gone to a hospital setting.

A six-year study of medicaid clients in New York City showed that comprehensive ambulatory maternity care provided by nurse-midwives offfered savings ranging from $855 to $1840 when compared with normal birth charges in 13 Manhattan hospitals.[8]

In a California study, nurse-midwives had a greater than 50% decline in neonatal mortality and premature births for a sample of disadvantaged women. Two years after the nurse-midwife services were terminated, the neonatal mortality had tripled.[9] The costs of neonatal intensive care for high-risk newborns are very high in comparison to the costs of preventive services offered by nurse midwives.

Because of the cost savings that nurse-practitioners bring to the health care system, we propose increased levels of authorization under the Nurse Training Act.

SPECIAL PROJECTS

Funding for special projects is intended to promote career mobility and educational advancement for all types of nursing programs and for nurses currently in practice. This is especially important for the many nurses who are single parents or middle-aged women who may lack the financial resources to continue their education.

In the present bill, special projects addresses the problem of the nursing shortage by providing funds for nurses seeking reentry into practice and for education of paraprofessionals. Funds for student recruitment and continuing education are also included.

It is now proposed that grants for special projects will emphasize problems in the distribution of nurses and will remain a category where many ongoing needs of the profession can be included. For example, in underserved areas, one means of increasing the nursing supply is to give area residents greater access to all types of nursing education. Schools could operate outreach or off-campus programs to train students in locations which are closer to their homes or work places. This would be especially important in areas of gerontology and community health, where the needs are greatest.

Recruitment of minority and disadvantaged students was also cited as a priority in the IOM study. In 1981, blacks comprised 5.2% of graduates of all basic RN programs, while students of hispanic origin totaled only 2.3%. American Indians and Orientals combined were only 1.3% of all basic RN graduates.[10]

Additional funding for recruitment of students from minority backgrounds is important, not only in terms of educational opportunities, but in terms of the possible improvements in the access of care for underserved populations.

Evidence already exists supporting the notion that "people who live in an area are more likely to remain or return there than are those attracted for limited tours of service."[11] This further justifies the needs for educational outreach of nursing activities and special efforts to recruit nurses from minority and disadvantaged backgrounds. In order to subsidize these programs, funding levels higher than currently authorized would be required.

STUDENT FINANCIAL ASSISTANCE

If nursing is to continue to generate the number of graduates needed to maintain our nation's supply of nurses, then federal assistance in the form of student loans and traineeships must be forthcoming. Lack of federal funds for nursing students would mean a serious decline in the number of nurses prepared - especially students from families who are at a socio-economic disadvantage.

Assuming full-time study for two years, the average young person faces a cost of tuition and living expenses of $20 to $30,000, in addition to a loss of income for that period.[12] A young person who seeks to borrow for graduate education will find relatively few low-cost options available, and the availability of commercial loans is generally based on one's current or future earning power.

Salaries for most nursing positions, although improving, are not as high as salaries for other professionals. For example, the most recent data on salaries for newly-licensed nurses show an annual salary of $18,360 in 1982-83. The salary expenditure curve in nursing is very flat, and has a poor salary progression. In contrast, entry level salaries for computer programmers are over $20,000, with excellent opportunities for salary progression.

We recognize that in the past, nursing students have had a high delinquency rate in their loan repayments. However, recently many schools have improved their performance standards. These schools should be allowed to continue in the student loan program as long as they maintain good faith efforts in reducing previous delinquency rates. The $16 million revolving student loan fund is not enough in view of the burdensome costs of education, the need to provide loans to students in new nursing programs, and the special needs of financial assistance for students of minority and disadvantaged backgrounds.

DEMONSTRATION PROJECTS

This year, we are urging authorization for the creation of a new category: Demonstration Projects. These projects, which could improve access to and quality of nursing services could have a significant impact on our nation's cost and quality of care.

The IOM report on nursing cited how many nursing service administrators believe that nursing educators are not preparing students to assume the responsibilities of clinical nursing. Similarly, many nurse educators believe that nursing service administrators fail to provide environments allowing nursing graduates to practice at the level of professional skill for which they have been prepared.[13]

The IOM report endorses collaborative arrangements between nurse educators and nurses in practice settings. It states that this collaboration would require "special funding and staff to test untried relationships and to develop new patterns of accountability." The report concludes that the non-Federal sectors will not be able to provide necessary funding for this collaboration.[14] Because these demonstration projects would contribute to improving patient care, and because they cannot be included in any other category, they warrant authorization as a separate line item of legislation.

Although nurses are involved in other demonstration projects sponsored by agencies such as the Health Care Financing Administration and the National Center for Health Services Research, the demonstration projects which we are recommending do not meet the criteria of these other agencies. Therefore, we strongly urge that these projects be directed by that part of the federal government that oversees the nursing profession: The Division of Nursing.

NURSING FELLOWSHIPS

Little attention has been devoted to mobilizing the knowledge and abilities of nurses, the largest group of providers who are specially trained in developing and implementing reform from within the system. Research-based changes in nursing care can lead to cost savings at least as great as those produced by utilization review.

Twenty-six universities now award doctoral degrees in nursing. Although total enrollments in doctoral programs have continued to rise, the number of part-time students has steadily increased. This is largely a result of the scarcity of funds for full-time doctoral study. In 1982, part-time students were over 50% of total doctoral enrollments. This large proportion of part-time students delays the rate at which doctoral degrees are granted.

For full-time doctoral students, pre-doctoral National Research Service Awards currently offer less than a million dollars for nursing fellowships. In many doctoral programs, this is the only form of student assistance available for full-time students. Because the opportunities for nursing fellowships are limited when compared with other disciplines, the National League for Nursing strongly urges the Committee to establish an authorized item for fellowships under the Nurse Training Act.

NURSING RESEARCH

The nurse's orientation is quite different from the orientation of the physician. The physician seeks to diagnose and, when possible, treat a pathologic syndrome. Nurses, in addition to carrying out the therapeutic regimen prescribed by the physician, seek ways to help the healthy individual maintain the best physical and mental status possible and to help the individuals with specific health problems to deal with their situations in the most positive way possible.

There are numerous studies demonstrating reductions in post operative complications, hospital stay, and use of analgesics as a result of preoperative teaching provided by nurses. In one study, infection control practitioners (75% of whom are nurses) were proven effective in decreasing the occurence of hospital acquired infections. This is critical when one considers that currently in this country we have 2,007,000 hospital acquired infections per year, half of which are preventable, and that these infections result in 6,409,000 additional hospital days, for a total cost of one billion dollars.

In another study, nursing intervention among mothers with a history of child abuse resulted in improved health of 88% of the children observed and no need for hospitalizing these children. This was in dramatic contrast to the control group in which 90% of the children were hospitalized as a result of parental abuse or neglect.

The 1983 IOM study brought the need for nursing research to the attention of the scientific community and advocated a federally-sponsored center for nursing research as cited below:

> "A substantial share of the health care dollar is expended on direct nursing care, yet the professionals who deliver this care work without the benefit of a strong organizational base to stimulate and support scientific investigation in their field. The committee believes that a center of nursing research is needed at a high level in the federal government to be a focal point for promoting the growth of quality nursing research."[15]

Nursing research funds have been administered under the direction of the Division of Nursing, Bureau of Health Professionals, Health Resources and

Services Administration, DHHS. Though the administration of these funds has been excellent, the Division of Nursing is not as visible to the public or to Congress as the National Institute of Health. Nursing this year (1984) was allocated $9 million; a sad contrast to the $3.6 billion NIH budget.

If one accepts the premises that nursing is an important component of the U.S. health care system and that research is an essential mechanism in any profession to improve the quality of practitioners and services provided, then one must conclude that there is inequity in the allocation of federal research and development funds.

The most traditional and acceptable method to assure the successful completion of vital health research has been through the NIH. Since NIH is the vanguard, the recognized leader of biomedical research in the nation, the minimal support of nursing research within NIH is appalling. If nursing is to be brought into the the mainstream of scientific investigation, there must be a visible, coordinated, and active effort within the auspices of NIH. Any such research endeavors at NIH would involve working in a collaborative way with existing NIH components and structures, enhancing rather than interfering or competing with other research efforts. Nursing research is indeed unique in what it offers to the health of the nation.

The National League for Nursing firmly supports the formation of a National Institute of Nursing, as passed by the House of Representatives last fall (HR 2350). A strong federal presence for nursing research is important, not only because it would strengthen nursing research endeavors, but also because of the improvements and cost savings it would bring to our nation's health care system.

We appreciate the opportunity to present our views and hope the Committee will give serious consideration to our recommendations regarding the need for increased funding for nursing education and nursing research.

We would be pleased to respond to any request for clarification or further information.

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The American Association of Nephrology Nurses and Technicians
AANNT

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March 23, 1984

Honorable Orrin G. Hatch, U.S. Senate
Chairman, Senate Labor and
Human Resources Committee
527 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Hatch:

The American Association of Nephrology Nurses and Technicians is an organization of 3500 members who specialize in the care of the End-Stage Renal Disease patients.

Our organization wholeheartedly supports the nurse training re-authorization bill you plan to present. We are particularly supportive of increased funding for advanced nurse training, nurse practitioners and student loans. If anything, we would, of course, prefer to see the proposed authorization number raised.

In addition, AANNT also supports the concept of the National Institute of Nursing which was discussed at your hearings on March 14, 1984.

Many thanks for the opportunity to demonstrate our support on these very important issues.

Sincerely,
Mary Baker, RN, M.S.
Mary Baker, R.N.,M.S.
President

MB:cws

AANNT National Office
North Woodbury Road / Box 56, Pitman, New Jersey 08071
Telephone: (609) 589-2187

AUPHA
ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION
1911 NORTH FORT MYER DRIVE, SUITE 503/ARLINGTON, VIRGINIA 22209/(703) 524-5500

GARY L. FILERMAN, Ph.D.
President

March 23, 1984

The Honorable Orrin Hatch
Chairman
Senate Labor and Human Resources Committee
Hart Senate Office Building, Room 527
Washington, D.C. 20510

Dear Senator Hatch:

We very much appreciate the opportunity to add our testimony to the health professions education program record.

Two copies of our statement are enclosed.

Sincerely yours,

Gary Filerman /jwl
Gary L. Filerman, Ph.D.

GLF:jwl
Enc.2

17 York Street, Suite 100 • Ottawa, Ontario, K1N 9J6

Statement by

Gary L. Filerman, Ph.D.
President

Association of University Programs
in Health Administration

March 23, 1984

Mr. Chairman and Members of the Committee:

On behalf of the nation's health administration programs, I would like to thank you for affording us the opportunity to submit testimony in connection with the reauthorization of health professions education programs.

By way of background, the Association of University Programs in Health Administration (AUPHA) is a 36-year-old consortium, consisting of 153 health administration programs in 144 colleges and universities throughout the world. These educational programs are designed to strenthen and improve administrative and managerial leadership in the health care delivery system.

The Critical Need for Competent Health Administrators

Recently, Mr. Chairman, this Committee heard testimony from Dr. Edward N. Brandt, the Assistant Secretary for Health. In his statement, Dr. Brandt quite accurately pointed out the new demands for well-trained health administrators as a result of changing patterns of organization and practice. This country is experiencing well-documented shortages of professionally trained administrators for home health agencies, long-term care facilities, rural hospitals, HMOs, and PPOs. However, Dr. Brandt failed to mention the fact that, new organizations aside, the current work force of health administrators is seriously lacking in education and management skills training. In fact, it is estimated that two-thirds of the nation's health administrators have not received adequate training and education for their jobs.

Mr. Chairman, this country needs an effective health administration education system to accomplish the goals of improved health services productivity, competition, and the expansion of alternative delivery systems. These objectives will not be achieved without a more adequate supply of competent health administrators.

Today, for example, expenditures for health care consume 10.5 percent of the GNP, or about double the share held in 1960. If current trends are allowed to continue, national health care costs will grow to account for as much as 12 percent of the GNP by 1990.

As the members of this Committee are well aware, increases of this magnitude would eventually threaten a serious hemorrhaging in our society. For this reason, the Congress and the Executive Branch are examining a variety of cost containment measures designed to slow the growth in health care costs. Virtually all of these measures, including the recently enacted prospective payment system, are dependent upon there being an adequate supply of competent health services managers. They are the individuals who are ultimately responsible for administering cost containment measures, as well as grappling with problems of nursing shortages, physician availability, and practitioner competence.

In short, health services administrators could accurately be regarded as the linchpin of our health delivery system. Yet, as I mentioned earlier, two-thirds of the nation's health administrators have not received adequate training and education in this field. As a result, (1) our efforts at cost containment are weakened and fall short of expectations, and (2) hospital facilities and health professionals continue to function less productively, in inadequately managed settings.

In light of these facts, Mr. Chairman, one can only conclude that the Administration's proposal to terminate authorizations for health administration programs is misguided. The overwhelming evidence points to the need for an expanded effort in this area. For, as Dr. Brandt pointed out, the health delivery system is lacking in the key resource necessary to implement effective cost controls and for the development of low cost alternative services.

Health administration programs are the primary source for attracting young people to careers in health management, training them properly, and for upgrading present managers. These programs respond to the task by keeping students abreast of new developments in health management, teaching cost containment to other health professions, conducting management research, and offering continuing education.

Title VII of the Public Health Service Act authorized two programs in health administration:

- Graduate Programs in Health Administration - Section 791

  Under this program, grants are awarded to public or nonprofit private educational institutions to support graduate programs in health administration, hospital administration, and health planning. The program is successful in increasing nonfederal investment in training for health services management. To participate in this program, institutions must provide a minimum base of nonfederal funds. Currently, every federal dollar generates three or more dollars in nonfederal support.

- Health Administration Traineeships - Section 791A

  Under this program, grants are awarded to public and nonprofit private educational institutions. The grants support traineeships for graduate study in accredited programs in health administration, health policy analysis, and planning. The programs are located in a variety of graduate schools, including health sciences, business, and public administration. The traineeships must serve primarily minority and mid-career students.

The federal investment in these programs is comparatively small, yet remarkably effective. Furthermore, the enabling statute has succeeded in stimulating nonfederal support for these programs. (Historically, federal funds have been over-matched by a better than three-to-one ratio.)

Recommendation

The AUPHA recommends modest increases in both the graduate programs activity and in traineeships. This increase is necessary to assist an expanded number of programs.

	1985	1986	1987
Graduate programs in health administration (Section 791)	$3,000,000	$4,000,000	$5,000,000
Traineeships (Section 791A)	$1,000,000	$1,500,000	$2,500,000

In keeping with the programs' objective of encouraging nonfederal support, AUPHA recommends that the threshold requirements for nonfederal support be raised to $200,000 for fiscal year 1985, $225,000 for fiscal year 1986, and $250,000 for fiscal year 1987.

Mr. Chairman, I will be happy to provide any additional information the Committee desires. I want to thank you again for the opportunity to present testimony on this most important subject.

Association of
Teachers of
Preventive
Medicine

1015 15th Street, NW, Suite 403, Washington, DC 20005 (202) 682-1698

April 11, 1984

Senator Orrin G. Hatch
Chairman
Committee on Labor & Human Resources
United States Senate
Room 527 - Hart Building
Washington, D.C. 20510

Re: Health Professions Education

Dear Senator Hatch:

We understand that your committee will be meeting soon to mark-up reauthorization legislation for health professions training. I am writing to submit our views regarding a provision of existing law that authorizes support for residency training in preventive medicine. I would also request that this letter be made a part of the hearing record on the subject.

The Association of Teachers of Preventive Medicine is an academic society composed of teachers and researchers in the field of preventive medicine and community health.

A substantial portion of our membership also includes medical school departments of preventive medicine. As such, our organization has had a long-standing interest in federal authorities which foster the teaching of prevention. When current health professions authorities were debated and enacted three years ago, the ATPM played an active role in eventual enactment of Section 793 of the Public Health Service Act.

The Administration has proposed that for fiscal year 1985, $1 million be authorized for preventive medicine residencies. Given the history of this program and the needs it was designed to address, this ceiling would clearly be insufficient.

During the first year that this program was funded, FY83, $1 million was appropriated. These funds were awarded to twenty (20) schools of medicine and public health to support seventy-three (73) residents. In FY83, commitments were made to these programs for a three-year period through FY85. As the enclosed chart indicates, at that time the Division of Medicine contemplated a growth in funding for an additional eighteen (18) residents in year 02 of the program, and a leveling off of support for ninety-one (91) residents in year 03.

FY83 funds, however, were used for an abbreviated funding cycle of only three months during that fiscal year, from July 1 - September 30, 1984. As a result, an increase of funding was required for year 02, which was for nine months (October 1, 1984 - June 30, 1985) just to keep pace with continuation support for the seventy-three (73) residents funded in year 01. Therefore, for FY84, Congress appropriated $1.6 million for this program to assure level funding.

FY85 funds will therefore be used for year 03 of this program, the funding cycle for which will constitute a full twelve months, from July 1, 1985 through June 30, 1986. In addition to stretching year 02 funds further by compressing them into a nine-month period, the Division of Medicine also changed the funding cycle to make it consistent with the academic cycle of funding residents.

The affect of these changes in the funding cycle for the program means that in FY85, $2.3 million will be needed to continue funding at the original level of seventy-three (73) residents. Because year 03 of the program will be for a full twelve months, continuation funding needs will level off in that year.

As the above indicates, therefore, reauthorization ceilings will need to be higher than the current funding level for this program if actual cutbacks are to be avoided. Given that the overall funding level relative to need is so small already, we would encourage a close examination of this program during your consideration of its reauthorization to assure that its purpose is not jeopardized.

As always, we would be pleased to assist your committee in any way that we are able as it considers this matter.

Sincerely,

John M. Last, M.D.
President

JML/lbk

cc: David Sundwall, M.D.

GRANTS FOR PREVENTIVE MEDICINE RESIDENCY TRAINING

APPLICANT	FY 1983	FY 1984	FY 1985			
	Budget Periods					Project Period
	01 Year (3 mos.)	02 Year (9 mos.)	03 Year (12 mos.)	04 Year	05 Year	
University of Maryland, MD	34,478	122,912	122,912	-0-	-0-	280,302
Univ. of North Carolina, NC	79,124	114,420	114,420	-0-	-0-	307,964
Tulane University, LA	40,850	120,650	120,650	-0-	-0-	282,150
University of Arizona, AZ	48,867	116,539	140,484	-0-	-0-	305,890
Loma Linda University, CA	52,099	120,728	120,728	-0-	-0-	293,555
University of Ca., L.A., CA	40,700	69,737	64,737	-0-	-0-	175,174
University of Michigan, MI	38,460	92,320	126,340	-0-	-0-	257,120
Univ. of California, Berkley, CA	43,704	113,982	113,982	-0-	-0-	271,668
University of Alabama, AL	84,180	108,240	108,240	-0-	-0-	300,660
Ohio State University, OH	27,632	94,528	94,528	-0-	-0-	216,688
SUNY, Stony Brook, NY	67,786	147,707	146,846	-0-	-0-	362,339
Johns Hopkins Univ., MD	41,489	137,074	137,074	-0-	-0-	315,637
University of Washington, WA	27,845	101,492	101,492	-0-	-0-	230,829
Mt. Sinai Medical Center, NY	55,593	85,500	80,640	-0-	-0-	221,733
University of Illinois, Chicago,IL	48,150	159,600	159,600	-0-	-0-	367,350
Med. College of Wisconsin, WI	38,052	78,995	82,377	-0-	-0-	199,424
University of Hawaii, HA	40,893	50,471	51,971	-0-	-0-	143,335
University of S. Carolina,Columbia	69,437	129,680	107,293	-0-	-0-	306,410
University of Rochester, NY	41,246	171,334	171,334	-0-	-0-	383,914
Oregon Health Sciences University	3,310	53,498	53,498	-0-	-0-	110,206
Total	$923,895	$2,189,407	$2,219,146	-0-	-0-	5,332,348
Indirect Costs (8%)	73,647	170,873	173,252	-0-	-0-	417,772
TOTAL	$997,542	$2,360,280	$2,392,398	-0-	-0-	$5,750,120
Number of Residents	73	91				
Program Support	$412,540	$377,304				
Stipend Support	511,355*	1,812,103				

*differences in totals due to indirect costs

Average Stipend: $20,000/year Additional cost for 18 residents in year two: $460,000

ANSR
Association of NHSC
Scholarship Recipients

April 18, 1984

Mr. James Powell
Labor and Human Resources Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Powell:

I respectfully request that the enclosed be included in the hearing record on S.B. 2281, on the reauthorization of the National Health Service Corps. Thank you.

Sincerely,

S. Newman, M.D.

Stephen Newman, M.D.
President ANSR

2124 Kittredge Street Suite S Berkeley CA 94704 (415) 841-6500 ext. 512

ANSR
Association of NHSC
Scholarship Recipients

April 4, 1984

Testimony of Stephen R. Newman, M.D.
Senate Labor and Human Resources Committee

I would like to thank you for permitting me to submit this testimony. My name is Stephen Newman. I am a third year family practice resident at San Francisco General Hospital, and a National Health Service Corp Scholarship recipient. I will begin four years of obligated service this July. I am here on behalf of the Association of National Health Service Corp Scholarship Recipients (ANSR), which represents scholarship recipients from 48 states in all levels of training. ANSR was formed last fall by obligated health professionals who were distressed about recent changes in the philosophy of the National Health Service Corp (NHSC).

As a first year medical student at George Washington University in 1977, I recall meeting with the Corp director on our campus. I remember the vision we shared of a new form of health care delivery for those patients, who for reasons of geography, language, or poverty, were unable to receive medical attention. I remember the vision of an expanding Corps with federally funded providers working in federally assisted sites, on Indian reservations, in rural areas, and in our inner cities. I remember the promise of a career with the NHSC for those of us who found the Corps preferable to traditional private practice. Seven years later as I look forward to serving my obligation, I have discovered that the Corp has undergone significant changes; changes which my colleagues and I believe violate the spirit and intent of Congress and deprive thousands access to health care.

The impact of cuts in federal public health programs is having repercussions throughout the country. According to statistics provided by the National Health Law Program, eight states and 32 urban areas report alarming increases in infant deaths since 1981. As community health centers have been forced to cut services, and in the worst cases close their doors, and as fewer and fewer private physicians are willing to see Medicaid patients, NHSC doctors and dentists can fulfill an important and growing need. Unfortunately, recent Corps policy changes have altered the mission of the Corps and thus its ability to respond to pressing needs. In this regard we have two specific concerns.

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Stephen R. Newman, M.D.

In the last six months, 40% of all Health Manpower Shortage Areas (HMSA's) have been dedesignated--most of them urban. Harlem, the South Bronx, East Los Angeles, Detroit and Atlanta are not "needy" enough to warrant HMSA designation, despite the fact that health status indicators for these poverty ridden communities remain among the worst in the country. As a consequence of losing HMSA designation, these needy communities can no longer recruit NHSC physicians or dentists. How does the administration justify this action? They subscribe to the diffusion theory, a yet unproven hypothesis which assumes that physician maldistribution will be corrected through the operation of competitive market mechanisms. In other words, intense competition resulting from a predicted oversupply of physicians will force physician migration into the least desirable practice locales--urban ghettos.

This position represents a significant departure from longstanding Congressional intent that the NHSC serve the needs of both urban and rural shortage areas, and in some instances, clearly ignores recommendations of state health planning agencies regarding needs in their states. In dedesignating urban areas, we believe that the Administration is blatantly misinterpreting the law and regulations governing HMSA designation. Furthermore, this discriminatory interpretation will mean that the quality of care received by many inner city residents will deteriorate. The consistent medical manpower provided by Corp health professionals will no longer be available.

We believe federal policy should continue to recognize and support the health manpower needs of urban, inner city communities. We urge Congress in this reauthorization process to reaffirm its intent that the NHSC serve both urban and rural areas. We urge the Congress to review these regulations and ensure that the Administration's interpretation is consistent with Congressional intent.

In its process of identifying placement sites for NHSC professionals this year, Corp administrators imposed a new criteria which is clearly biased against the urban poor. This "Attractiveness Index" fails to consider a population's need for medical services, focussing solely on geographic access. This criteria was developed and implemented without any public review or comment. We believe that NHSC placement policy must recognize barriers (language, economic, cultural) in addition to geography. For this reason, we recommend that the Attractiveness Index be abolished.

Stephen R. Newman, M.D.

ANSR fully supports the concept of the Private Practice Option. As many of our members have unfortunately discovered, some sites slated for the Private Practice Option (PPO) cannot support a physician in private practice. Doctors are forced to assume large capital expenditures at their own risk. The Corp's promise of technical assistance in helping physicians to develop viable PPO's is not always made available. In this year's placement cycle, 40% of all placements are to be PPO. We believe that scarce federal resources should be targeted to communities that cannot financially support a private practice. Federal salaried positions should be allocated to the areas of greatest need (HMSA's 01 and 02). The PPO should be allowed in any HMSA (01-04) pursuant to PL 97-35.

In authoring the legislation, the Congress astutely recognized the importance of a suitable match between the obligee, his or her family, and the underserved community in promoting retention of Corps personnel. This is apparently not a priority for NHSC administrators. ANSR has documented numerous inappropriate matches where families are forced to live apart, bilingual health professionals are not utilized effectively, and where physicians are not appropriately trained to meet the medical needs of the community.

Upon leaving residency training, young physicians are faced with the awesome duty of being solely responsible for patient care. This is an immense responsibility for Corps physicians working in isolated rural communities where medical back-up is not always available. The NHSC's expectation that physicians, against their own good judgement, will practice beyond their scope of training is not acceptable to ANSR. Pediatricians, should not be expected to deliver babies and treat adult diseases.

When my colleagues and I joined the NHSC we understood that a major Corps goal was to encourage obligated physicians to continue to practice in underserved areas after they completed their obligations. We understood that the NHSC was designed to address the long-term problems of medically needy communities; not to provide a temporary infusion of medical manpower. Although retention appears to have been successful in previous years when placement opportunities were less restrictive, comments ANSR has received from obligees in the present placement cycle lead me to believe that the retention rate for this group will be dismal. We feel it is imperative that Congress seek to ensure enforcement of Section 333(f) of the 1981 Public Health Service Act which clearly stipulates that the NHSC attempts to make suitable matches between obligees, their spouses, and underserved communities.

I would also like to bring to your attention the serious problems obligees are experiencing with the Corps. This year's placement cycle provides many examples.

- With less than two weeks left in the 1984 placement cycle matching process, obligees who had tentatively matched to sites under the Early Decision Alternative in September, are now being notified that their match is disapproved as a consequence of the rampant dedesignation. This ill-timed action leaves obligees and dedesignated communities with few options.

- Placement opportunity lists sent to obligees last summer contained many sites that were in fact not sites. Unfortunately, many obligees did not learn this until they spent considerable time, money, and effort developing a site.

- Obligees, who request an extension of their deferment period, but not beyond the allowable three years, are forced to sign a Conditional Service Agreement, essentially agreeing to waive all rights to participate in the matching process.

ANSR can provide extensive documentation of these problems. We believe this situation warrants an in-depth Congressional investigation into the administrative practices of the NHSC.

There are two final concerns I would like to bring to your attention. Prior to the 1983-84 academic year, students on NHSC scholarships received the equivalent of a $550 per month living stipend and an educational expense allowance. Last year, Congress eliminated the allowance and cut stipends by $200 per month, forcing students to take out loans to meet basic living expenses. These loans, as well as loans incurred during undergraduate education, will become due when students begin serving their obligation. Faced with present salary levels, NHSC obligees will have a difficult time repaying loans while supporting their families. The $9,000 salary cut imposed on obligees beginning service last July reduces salaries for this group below the 1978 level. In effect, those of us who chose to continue residency training are being punished. Had I elected to serve my obligation after completing only a one-year internship, two years ago, I would receive a higher salary than my colleagues who were board certified. Certainly, I am more valuable to the Corps as a family practitioner than a general practitioner. ANSR believes that those of us who accepted a NHSC scholarship instead of a military scholarship should not be penalized. We believe Congress should appropriate sufficient funds to provide students on NHSC scholarships the educational expense allowance and a realistic monthly stipend. Parity should be re-established between those who chose the military scholarship and those of us who chose the Corps. Furthermore, salary levels should reflect training and skill rather than the date an obligee commences his or her service obligation.

It is my understanding that the NHSC was designed to serve as a match-maker between health professionals and underserved communities. The goal was to make a good stable marriage between the two; one that would endure beyond the doctor's obligated service. This makes sense, and is an important long-range step in alleviating physician maldistribution. The present situation bears more resemblance to a shotgun marriage, these unsuitable matches will not promote retention and underserved communities will not enjoy a stable, long-term source of medical care. Should these policies continue over the next few years when the pipeline runs dry, the NHSC will have accomplished little in redistributing medical manpower. We urge the Congress in the course of the reauthorization of this legislation to review the overall mandate of the NHSC program and make those changes which are necessary to ensure that the longstanding goals of the program are met.

Again, I would like to thank you for the opportunity to testify before you today. I would be happy to answer any questions you may have and look forward to working with you and your staff in resolving these issues.

ANSR
Association of NHSC
Scholarship Recipients

ISSUES AND RECOMMENDATIONS

The Association of National Health Scholarship Recipients (ANSR), whose membership includes recipients from fourty-eight states and all levels of training, was formed last fall by scholarship recipients who were distressed about recent changes in the philosophy of the Corps.

INNER CITY COMMUNITIES DENIED NHSC PERSONNEL

Shortsighted interpretation of designation regulations has resulted in the dedesignation of 40% of all Health Manpower Shortage Areas (HMSA's), most of them inner city areas, within the last six months. These include Harlem, the South Bronx, East Los Angeles, Detroit and Atlanta. Despite the fact that health status indicators for these poverty ridden communities remain among the worst in the country, they can no longer recruit NHSC physicians or dentists.

As presently implemented, the HMSA designation process:

- ignores longstanding Congressional intent that the NHSC serve the needs of both urban and rural shortage areas,
- ignores recommendations of state health planning agencies regarding needs in their states, and
- does not adequately consider economic, cultural and language barriers which restrict access to health care services.

RECOMMENDATIONS

1) Federal policy should continue to recognize and support the health manpower needs of urban inner city communities. Congress should reaffirm its intent that the NHSC serve the needs of both urban and rural areas.

2) The HMSA designation regulations must be reviewed to ensure that the Administration's interpretation is consistent with Congressional intent.

NHSC PLACEMENT POLICY

NHSC placement policy has undergone major changes in the last year:

- A second layer of site designation criteria imposed by Corps administrators discriminate against the urban poor whose need for medical services is not considered in the process of identifying placement sites. This criteria was developed and implemented without any public review or comment.
- Many of the NHSC sites slated for the Private Practice Option (PPO) do not have a sufficient financial base to sustain a private practice forcing obligees to assume large capital expenditures at their own risk. Technical assistance promised by the Corps to assist physicians in assessing the viability of a site, is often not available.

RECOMMENDATIONS

1) The so called "Attractiveness Index" should be abolished.

2) Federally supported NHSC positions should be targeted to the areas of greatest need (HMSA's 01 and 02). The PPO should be allowed in any HMSA (01-04) pursuant to P.L.97-35.

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NHSC PLACEMENT POLICY (continued)

- Contrary to Congressional intent which clearly stresses the importance of a suitable match in promoting retention of Corps personnel in underserved areas, NHSC administrators make little, if any, attempt to match a health professional's ethnic background or family circumstances with the underserved community where he or she is assigned.

- Many NHSC physicians, against their own good judgement, are expected to practice beyond their scope of training. Pediatricians, for example, are expected to deliver babies and treat adult diseases.

RECOMMENDATIONS

3) Congress should seek to ensure enforcement of section 333(f) of the Public Health Service Act which requires the Secretary to "assign to an area a Corps member who has (and whose spouse ha has, if any,) those characteristics which are characteristics which increase the probability ot the member's remaining to serve the area upon completion of his assignment period."

ADMINISTRATIVE PROBLEMS PLAGUE THE NHSC AND THREATEN ITS VIABILITY

- Obligees in the 1984 placement cycle have been subject to late information, misinformation and contradictory information regarding placement opportunities, creating undue hardship for obligees, their families and the underserved communities. This is partially attributed to communication problems between the Central Office and the Regional Offices.

- With less than two weeks left in the 1984 placement cycle matching process, obligees who had tentatively matched to sites under the Early Decision Alternative last September, are now being notified that their match is disapproved as a consequence of the rampant dedesignation. This ill-timed action leaves obligees and dedesignated communities with few options.

- No mechanism exists for impartial hearings for obligees placed in default of their obligation.

- Regulations have been changed repeatedly without public review or comment.

RECOMMENDATIONS

1) The Congress should conduct in-depth investigation into the administrative practices of the NHSC and seek to ensure that the program is administered consistent with Congressional intent.

STIPEND AND SALARY CUTS

- Educational expense allowances were eliminated and stipends were cut by 1/3 ($200/month) for students on NHSC scholarships. This forced many students to take out loans to meet minimum living expenses.
- Obligated Corps personnel suffered a $9,000 salary cut in 1983. Present salaries are below the 1978 level.

RECOMMENDATIONS

1) Congress should appropriate sufficient funds to provide students the educational expense allowance and a realistic monthly stipend. Parity should be re-established between those who chose a military scholarship and those who chose the NHSC.

ANSR

Association of NHSC
Scholarship Recipients

April 17,1984

Mr. Bruce Rogal
119 Church Street
Weston, MA 02193

Dear Mr. Rogal:

Your letter to Senator Kennedy was forwarded to me by that office for response.

Thousands of NHSC scholarship recipients across the country share your concerns regarding the present state of the NHSC. Many obligees, like your daughter Anne, selected the NHSC scholarship instead of a military scholarship or loan programs because they believed in the goals of the NHSC. Many planned to serve their obligation in urban areas. Unfortunately, few obligees will be allowed to serve in urban innercity areas because this administration does not believe that urban innercity communities are "needy enough" to warrant placement of NHSC physicians. ANSR believes that this policy is contrary to Congressional intent and clearly not in this country's best interest.

ANSR is deeply concerned about these issues and the effects recent NHSC policies are having on underserved communities as well as NHSC obligees. Two weeks ago ANSR testified before Congressman Waxman's House Subcommittee on Health and the Environment and presented these concerns. I have included a copy of that testimony for your information. We have also contacted Dr. Wesley Clark in Senator Kennedy's D.C. office. On March 21, the Senate Labor and Human Resources Committee (on which the Senator sits as Minority Chair) approved a bill authored by Senator Hatch reauthorizing the NHSC for three years. Although the Committee's proposed funding levels for the program substantially exceed recommendations made by the Administration, many of the other problems with the Corps were not addressed.

Thank you for sharing your concerns with Senator Kennedy. We hope that his staff will work with us to bring about the changes that are necessary to restore the program to its original goals.

Sincerely,

Sarah Jewel, MPH
Executive Director, ANSR

cc: Senator Kennedy
encl

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American Academy of Pediatrics

TESTIMONY

BEFORE THE

UNITED STATES SENATE

COMMITTEE ON LABOR AND HUMAN RESOURCES

ON THE

HEALTH PROFESSIONS TRAINING ASSISTANCE AMENDMENTS OF 1984

S. 2559

SUBMITTED BY
AMERICAN ACADEMY OF PEDIATRICS

APRIL 18, 1984

Office of Government Liaison
1300 North 17th Street
Arlington, Virginia 22209
703-525-9560/800-336-5475

The American Academy of Pediatrics is pleased to submit testimony on S. 2559, the "Health Professions Training Assistance Amendments of 1984." We commend the Chairman for his interest and support of the federal government's role in the education of health professional students, particularly in the area of primary care.

There are several aspects of the forthcoming reauthorization measure which warrant comment, foremost among them: training grants. Specifically, the Academy recommends that the Department of Health and Human Services renew emphasis on grants to 1) plan, develop and operate approved residency training programs in general pediatrics; 2) plan, develop and operate teaching programs for medical students in general pediatrics; and 3) plan, develop and operate programs for the training of physicians who intend to teach general pediatrics. Total authorizations for the above-mentioned initiatives should be set at not less than $20 million during each of the next three fiscal years as, in our judgment, that is the minimum sum sufficient to meet basic maternal and child health interests. Moreover, it is the considered view of the Academy that especially during a period of scarce resources, the primary care specialties should not receive arbitrarily disproportionate federal assistance.

To underscore the particular value of pediatric primary care training grants, the Academy commends to your attention data recently developed by the Ambulatory Pediatric Association, which initiated an analysis of both the programs and trainees funded by these grants during the past six years. Though the study is not yet complete, the results are so striking that we believe the preliminary data should be made available.

The enclosed data (see Appendix I) makes it clear that the grant has accomplished its major goal: the development of physicians committed to primary care practice. Of those pediatricians who trained with grant funding, 96 percent who are now in practice are in primary care, and 44 percent are working in socioeconomically deprived areas. More than half the programs responding cited that improvement in primary care curriculum and clinical training had occurred directly as a result of the grant. They further stated that a loss of grant support would result in a reversal of these gains, and a shift back to emphasis on subspecialty rather than generalist training in their teaching programs. It is obvious that the federal government's prior commitment to primary care training has been a fruitful investment. Such support has exerted a profound influence on the way in which primary care is taught. More faculty and better facilities have given primary care new credibility and respect in the eyes of physicians-in-training. Quality training is now being provided, and physicians are therefore more comfortable with primary care and more interested in providing it to patients. Removing or decreasing funding for this grant would reverse these gains throughout the country.

The relative availability of funds for research and training in the 1960s promoted the growth of subspecialization. The influence of these subspecialties and of the service funds associated with them was an important factor in bringing about emphasis on residency training in inpatient settings at the expense of training in ambulatory care. Traditionally, departments of surgery and medicine, as compared with departments of pediatrics, have received disproportionate levels of hospital and medical school support because of the revenue generated from their hospitalized patients. Lower rates of hospitalization and greater volume of ambulatory care have been contributing factors, and make it very difficult for general pediatric training programs.

Turning for a moment to the proposed bill's student assistance provisions, suffice to reiterate established Academy views. Medical students should be limited to an aggregate $80,000 in federally insured loans for their education, including tuition, fees and reasonable living expenses. Interest rates should be fair and variable in regard to need. Repayment on principal and interest should be deferred during medical school and length of residency, service in the armed forces, Peace Corps or National Health Service Corps. Repayment ought to be permitted over 10-15 years and begin 9-12 months after graduation.

The Academy also favors partial forgiveness of loan principal and interest in return for a minimum of two years of service in the NHSC or in a shortage area: 15 percent for one year; 20 percent each for the second and third year; and 25 percent for the fourth year. The amount of debt that can be paid in this fashion is 80 percent of the principal. Of course, in cases of death, permanent disability or the like, the loan should be totally discharged.

With respect to enrollment commitment, the Academy would applaud legislation that aims to release recipients of grants, loan guarantees and interest subsidies (such as medical schools) from any contractual obligation to fulfill related enrollment increases. It is an effort long overdue.

But there are other efforts equally overdue if the government is genuinely serious about seeking to deliver adequate, cost-effective health care to all Americans. Clearly today, advances in prevention and control of traditional acute and infectious diseases permit the pediatrician to devote more time and attention to what have been relatively neglected areas -- chronic disease; the increasing number of behavioral problems of childhood and adolescence; and what we call biosocial problems -- those health problems socially induced or complicated by social and environmental factors. Because coping with the challenges of modern society will cause an increase in the incidence of biosocial problems, modern pediatric training must be directed more specifically to the treatment of those problems.

The content of experience in biosocial pediatrics should include normal and abnormal growth and development, basic behavioral science information, reactions of children of various ages to illness, education for healthy lifestyles and familiarity with the principal literature regarding child development. Residents should also learn about the nature of psychologic and achievement tests, the principal psychologic therapies, the principles of psychopharmacology, and the techniques of family counseling. They should be familiar with the development characteristics of the parent-child interaction, child care practices and dysfunctions in parenting.

Residents should learn to manage such family crises as death and bereavement, suicide attempts, sexual assault, accidents, child abuse, birth of a defective child, separation, divorce, abortion, and a wide range of common behavioral disorders. Furthermore, they should be able to work with the family to resolve problems in parenting, well child care, adoption/foster care, school adjustment, and learning. They should be familiar with the role of the pediatrician in the management of disease states in which psychological elements play an etiologic or contributory role.

There has been also a dramatic increase in our recognition of child health problems associated with poverty, a deteriorating physical environment, changing family structures and other social and psychological factors. There is growing eveidence that encouragement of health promotion and changes in lifestyles may become more important than medical intervention in affecting morbidity and mortality. The pediatric community recognizes that pediatric education must respond to these changes in child health needs. We ask Congress to follow suit by authorizing the funds to allow us to develop and maintain an educational program relevant to those needs.

Pediatric programs have, in fact, begun to evidence a shift in emphasis toward treatment of biosocial disorders through a strengthening of ambulatory training. But the shift has been slight, and the bulk of pediatric training still takes place in hospital settings even though the burden of care for children with such problems remains largely in the community. We simply cannot continue to all but ignore the relationship between biosocial and developmental disorders such as early family adjustment difficulties and school failure and adverse health effects of those problems. A recognition of that relationship mandates pediatric education which emphasizes the processes of human growth and development and their relationships to health and disease.

Because pediatrics is a primary care discipline, and because most pediatric problems are best handled on an outpatient basis, pediatric education should utilize the skills and demonstrate the commitment to personal, continuous care practiced by the general pediatrician. The current preponderance of hospital-based teaching in the pediatric curriculum is one indication of the dissonance between current pediatric education and the health needs of children. By the completion of formal postgraduate training, most pediatricians are extraordinarily skilled at diagnosing and managing illness, especially that of hospitalized children. As a consequence of concentrating pediatric resident education on illness, may if not most pediatric residents have only a rudimentary knowledge of the concept of normality and particularly of the variability surrounding the "average" with regard to child development and health status.

In the future, pediatricians will be called upon more and more to manage children with emotional disturbances, learning disabilities, chronic illnesses and other problems of a developmental, psychological and social nature. They will provide increased amounts of health care to adolescents. They will be expected to manage their practices efficiently, collaborate with other members of the health care team and use community resources to enhance the effectiveness of services to children and their families.

The ambulatory experience responds to these needs by developing skills in counseling, anticipatory guidance, developmental appraisal, referral, consultation, use of screening procedures and practice management. Skills relating to the care of children with chronic illnesses and handicapping conditions are particularly important. Finally, the ability to coordinate services, plan comprehensive care and mobilize available community resources is essential to provide ambulatory care of high quality. To accomplish all this, there remains a distinct need for faculty development and greater support for research related to ambulatory care. Full-time faculty members in ambulatory pediatrics need formal training in the discipline; it is no longer acceptable to assume that any pediatrician can teach ambulatory pediatrics.

Unfortunately, the pediatric community finds itself in the unenviable position of responding to a dramatic shift in educational need in an atmosphere of fiscal restraint. Moreover, increasingly larger percentages of medical school funds are being devoted to the delivery of patient care, a development which we recognize is a justified response to the public demand for quality health but one which means that other sources of support are necessary if service programs in educational centers are to improve the teaching environment -- particularly through the development of model ambulatory care programs. An appropriate program of grants for general pediatric training could respond to this need by earmarking funds for the development of ambulatory pediatric models. We would reiterate, also, that the Academy does not seek additional pediatric residency positions but, rather, the means to improve the quality of existing residency training and provide the necessary redirection of content.

The need for federal support of ambulatory training programs derives also from the present pattern of reimbursement for pediatric services by third-party payers. The funds used to support pediatric residencies are pooled from many sources, including Medicaid, other patient-care revenues, state appropriations and grants. Current reimbursement formulas directly and indirectly detract from the importance of ambulatory care and diminish pediatric department operating budgets by imposing restrictions on full reimbursement for ambulatory care. Medicaid reimburses well below the actual cost of providing ambulatory care in a teaching setting, and many private insurance policies do not cover ambulatory care. Sixty-five percent of families have no insurance covering office visits to a physician. Furthermore, procedure-dominated reimbursement systems tend to discriminate against the provision of preventive services, which constitute a large proportion of good pediatric practice. Simply stated, pediatric residency programs cannot further expand into ambulatory teaching without independent support. Only separate and dedicated federal funding can accomplish this teaching and training objective.

We believe increased financial support channeled into faculty salaries to be the most effective use of increased funding. Current circumstances find medical school faculty commonly forced to "earn their keep" by delivering medical care during non-teaching hours. This obviously detracts from teaching time and effectiveness. In the pediatric field, this problem is compounded by the generally longer hours required of practicing pediatricians and the above-mentioned disproportionate financial stress on pediatric departments. A more substantial federal support program would free pediatricians on medical school faculties to do their job, namely, to teach pediatrics to the best of their ability.

As the emphasis on teaching ambulatory care increases, pediatric departments will need to cope with the serious shortages of faculty to teach in such areas as adolescent medicine, learning disabilities, care of the chronically ill, ambulatory care, community pediatrics and the behavioral sciences. Faculty development in these areas will require financial support for fellowship and research positions in these disciplines. This means that pediatric education, which is already costly, will grow even more so if it responds to the obvious health needs of our nation's children. In the past we have been much slower to finance ambulatory and preventive care than catastrophic or tertiary care. However, it is increasingly clear that economical and effective health care depends much more on the former that the latter. We ask you to recognize this situation in this and future health manpower funding proposals.

Finally, the American Academy of Pediatrics would like to offer its services to aid in implementing some of the suggestions made above.

APPENDIX I

INITIAL DATA ANALYSIS

Impact of Primary Care Training Grants In Pediatrics

Questionnaire Survey of All Funded Programs 1977-1983

1. Program -- 75 percent of programs have responded -- Representing all geographical regions of the country. Fifty-three programs have received some support through this legislation over the past six years.

   a. Number of graduates -- 620

   b. Number of pediatric residents being trained as a result of these grants -- 2,189

   c. Number of faculty-FTE (Full Time Equivalents) being supported -- 132

   d. Percent of primary care residents actually funded by Grant (remaining percent indicates institutional commitment which exists)

   1977-78 -- 26 percent
   1978-79 -- 42 percent
   1979-80 -- 45 percent
   1980-81 -- 49 percent
   1981-82 -- 42 percent
   1982-83 -- 25 percent

2. Graduates -- Type of Practice

   a. 96 percent of graduates in practice are in primary care. This number compares with the estimate of the Annual Report of the A.M.A., 1980, which indicated that 73 percent of the pediatricians practicing in the U.S. were providing primary care.

   b. Of those graduates who chose fellowship training, almost 50 percent selected primary care fellowships.

   c. 44 percent are working in a socioeconomically deprived area.

3. Graduates -- Location

   a. 54 percent are in a large city/suburb.

   b. 24 are in rural areas or small towns.

4. Results if funding lost -- qualitative statements by program directors:

   a. More than 50 percent of programs reported marked improvement in curriculum, addition of community training sites (schools, camps, day care centers), improvement in ambulatory or outpatient care with better continuity of care provided, attraction of better quality trainees, and greater recognition within programs of the importance of primary care. These gains would be lost if funding is diminished or withdrawn.

   b. Most respondents felt a loss of funds would result in a decrease in the quality of primary care trining; emphasis would once again shift to inpatient, subspecialty training and lead to a decrease in well-trained primary care pediatricians.

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United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, D.C. 20510

March 19, 1984

Hearing on Health Professions Education - March 14, 1984

Data on Women and Minorities in the health professions
submitted for the record by Senator Edward M. Kennedy

Table C. NUMBER AND PERCENT OF FEMALE STUDENTS IN SCHOOLS FOR SELECTED HEALTH OCCUPATIONS: ACADEMIC YEARS 1970-71, 1975-76 and 1981-82

Health Occupation	1970-71			1975-76			1981-82		
	Total Students	Female Students	Percent Female	Total Students	Female Students	Percent Female	Total Students	Female Students	Percent Female
Medicine	42,638	3,955	9.3	59,687	11,889	19.9	71,602	19,613	27.4
Allopathic (MD)	40,487	3,894	9.6	56,244	11,527	20.5	66,298	18,505	27.9
Osteopathic (DO)	2,151	61	2.8	3,443	362	10.5	5,304	1,108	20.9
Podiatry	1,147	16	1.4	2,085	100	4.8	2,584	361	14.0
Dentistry	16,553	231	1.4	20,767	1,861	9.0	22,621	4,227	18.7
Optometry	2,831	82	2.9	3,888	456	11.7	4,741	1,077[1]	22.7
Pharmacy	15,625	3,370	21.6	24,416	8,113	33.2	20,468	9,673	47.3
Veterinary Medicine	5,006	467	9.3	6,274	1,488	23.7	8,156[2]	3,194[2]	39.2[2]
Public Health	*	*	*	6,461[3]	3,069[3]	47.5[3]	8,494[2,3]	4,642[2,3]	54.7[2,3]

[1] Data exclude three schools not in full operation in 1981-82.

[2] Data are for 1980-81.

[3] Female percentages are based only on total enrollments in programs responding to survey questions on minorities and women. Female enrollment numbers are estimated based on the assumption that the proportion of minorities in nonresponding programs are equal to those in responding programs.

*Data are unavailable.

SOURCES: For sources of data see the respective table for each occupation on enrollment trends by sex. Also Third Report to the President and Congress on the Status of Health Professions Personnel in the United States. DHHS Pub. No. (HRA) 82-2.

Table 8. NUMBER AND PERCENT OF MINORITY STUDENTS IN SCHOOLS FOR SELECTED HEALTH OCCUPATIONS: ACADEMIC YEARS 1971-72 and 1981-82

	1971-72						
Health Occupation	Total Students	TOTAL Minority Students	Percent Minority	Black Students	Percent Black	Other Minority Students	Percent Other Minority
Medicine	45,954	3,135	6.8	2,082	4.5	1,053	2.3
Allopathic (MD)	43,650	3,072	7.0	2,055	4.7	1,017	2.3
Osteopathic (DO)	2,304	63	2.7	27	1.2	36	1.6
Podiatry	1,268	40	3.2	27	2.1	13	1.0
Dentistry	17,305	1,081	6.2	597	3.5	484	2.8
Optometry	3,604	181	5.0	32	1.0	149	4.0
Pharmacy	16,322	1,645	10.1	618	3.8	1,027	6.3
Veterinary Medicine	5,140	133	2.6	96	1.9	37	0.7
Registered Nursing 1,2/	213,127	20,800	9.8	15,500	7.3	5,300	2.5
Public Health	*	*	*	*	*	*	*

Table D. NUMBER AND PERCENT OF MINORITY STUDENTS IN SCHOOLS FOR SELECTED HEALTH OCCUPATIONS: ACADEMIC YEARS 1971-72 and 1981-82 (CONT'D)

	1981-82						
Health Occupation	Total Students	Total Minority Students	Percent Minority	Black Students	Percent Black	Other Minority Students	Percent Other Minority
Medicine	71,602	10,025	14.0	3,988	5.6	6,037	8.4
Allopathic (MD)	66,298	9,724	14.7	3,884	5.9	5,840	8.8
Osteopathic (DO)	5,304	301	5.7	104	2.0	197	3.7
Podiatry	2,584	218	8.4	154	5.9	64	2.5
Dentistry	22,621	2,839	12.6	999	4.4	1,840	8.1
Optometry	4,741	447	9.4	57	1.2	390	8.2
Pharmacy	20,468	2,863	14.0	932	4.6	1,931	9.4
Veterinary Medicine	8,156 3/	377	4.6 3/	176	2.2	201	2.5
Registered Nursing 2,3/	238,473	23,315	10.6	14,365	6.6	8,950	3.8
Public Health 2,3/	8,486	2,041	24.0	*	*	*	*

1/ Data are for 1972-73.
2/ Minority percentages are based only on total enrollments in programs responding to survey questions on minorities and women. Minority enrollment numbers are estimated based on the assumption that the proportion of minorities in nonresponding programs are equal to those in responding programs.
3/ Data are for 1980-81.

*Data are unavailable.

SOURCE: Bureau of Health Professions Congressional Budget Data Cards and Minorities and Women in the Health Fields. For more detailed sources of data see the respective Chapter for each occupation.

TOTAL FIRST YEAR ENROLLMENTS AND FEMALE FIRST YEAR ENROLLMENTS IN SCHOOLS FOR SELECTED HEALTH OCCUPATIONS, 1982-83

	All First Year Enrollments	Female First Year Enrollments	Percent Female
Medicine	18,936	5,890	31.1
MD	17,254	5,462	31.7
DO	1,682	428	25.4
Podiatry	724	150	20.7
Dentistry	5,498	1,223	22.2
Optometry 1/	1,249	335	26.8
Pharmacy	6,574	3,496	53.2
Veterinary Medicine 1/	2,246	1,079	48.0
Public Health	Not Available	Not Available	Not Available

1/ These data are for academic year 1981-82 and are the latest available at present.

Table A-1-1. NUMBER AND ACCEPTANCE RATIO FOR APPLICANTS TO U.S. MEDICAL SCHOOL, BY GENDER: SELECTED ACADEMIC YEARS, 1961-62 THROUGH 1981-82

Academic Year	Number of Schools	Applicants*	Percent of Women Applicants	Percent Accepted Men	Percent Accepted Women	Applicants-Acceptance Ratio*
1961-1962	87	14,381	8.1	60.1	43.2	1.7
1967-1968	94	18,724	10.4	51.9	50.4	1.9
1971-1972	102	29,172	12.8	41.9	45.1	2.4
1977-1978+	122	40,569	25.1	39.2	40.0	2.5
1978-1979	125	36,636	26.1	45.6	43.7	2.2
1979-1980	126	36,141	28.3	46.9	46.3	2.1
1980-1981	126	36,100	29.5	47.9	46.4	2.1
1981-1982	126	36,727	31.8	47.7	45.7	2.1

Sources: 82nd Annual Report on Medical Education in the U.S. 1981-1982, JAMA, Volume 248, No. 24. December 24/31, 1982; Datagram, JME, Volume 48, February, 1973; and Datagram, JME, Volume 57, November, 1982.

*From the study of applicants, Association of American Medical Colleges.

+Applicant data given for 1977-1978 are for 119 schools and exclude the charter classes at Northeastern Ohio University, Rootstown; Marshall University in West Virginia, and Catholic University in Puerto Rico.

Table A-1-2. FIRST-YEAR U.S. MEDICAL SCHOOL ENROLLMENT+/, BY GENDER:
1978-79 THROUGH 1982-83

	1978-79 124 Schools		1979-80 126 Schools		1980-81 126 Schools		1981-82 126 Schools		1982-83 127 Schools	
GENDER	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Men	12,339	74.8	12,217	72.2	12,220	71.1	11,951	69.2	11,792	68.3
Women	4,162	25.2	4,713	27.8	4,966	28.9	5,317	30.8	5,462	31.7
TOTAL	16,501	100.0	16,930	100.0	17,186	100.0	17,268	100.0	17,254	100.0

+Includes student repeating, reentering or continuing.

Source: Fall Enrollment Survey, Association of American Medical Colleges, November 22, 1982.

Table A-1-2. (cont.) TOTAL U.S. MEDICAL SCHOOL ENROLLMENT, BY GENDER:
1978-79 THROUGH 1982-83

	1978-79 124 Schools		1979-80 126 Schools		1980-81 126 Schools		1981-82 126 Schools		1982-83 127 Schools	
GENDER	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Men	47,111	75.7	47,651	74.7	47,886	73.5	47,793	72.1	47,151	70.6
Women	15,102	24.3	16,149	25.3	17,248	26.5	18,505	27.9	19,597	29.4
TOTAL 100.0	62,213	100.0	63,800	100.0		*65,189	100.0	66,298	100.0	66,748

*Total includes 35 Students from whom gender was not reported.

Source: Fall Enrollment Survey, Association of American Medical Colleges, November 22, 1982.

Table A-1-3. FIRST-YEAR U.S. MEDICAL SCHOOL ENROLLMENT+ BY RACIAL/ETHNIC GROUP AND CITIZENSHIP
1978-79 THROUGH 1982-83

Racial/Ethnic Group	1978-79		1979-80		1980-81		1981-82		1982-83	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
U.S. Citizens										
White	14,048	85.1	14,259	84.2	14,262	85.0	14,218	82.4	14,085	81.6
Underrepresented Minorities										
Black	1,061	6.4	1,108	6.5	1,128	6.6	1,196	6.9	1,145	6.6
American Indian or Alaskan Native	47	0.3	63	0.4	67	0.4	70	0.4	62	.4
Mexican American/ Chicano	260	1.6	290	1.7	258	1.5	300	1.8	305	1.8
Puerto Rican (Mainland)	75	0.5	86	0.5	95	0.5	105	0.6	114	.7
(Subtotal)	(1,443)	(8.8)	(1,547)	(9.1)	(1,548)	(9.0)	(1,671)	(9.7)	(1,626)	(9.4)
Other U.S. Students										
Asian or Pacific Islander	452	2.7	502	3.0	572	3.3	765	4.4	936	5.4
Puerto Rican (Commonwealth)	179	1.1	226	1.3	241	1.4	250	1.5	229	1.3
Other Hispanic	151	0.9	188	1.1	224	1.3	247	1.4	278	1.6
(Subtotal)	(782)	(4.7)	(916)	(5.4)	(1,037)	(6.0)	(1,262)	(7.3)	(1,443)	(8.4)
Unidentified	—	—	—	—	—	—	6	0.0	9	0.0
Foreign	228	1.4	208	1.3	339	2.0	111	0.6	91	0.5
Grand Total	16,501	100.0	16,930	100.0	17,186	100.0	17,268	100.0	17,254	100.0

+First-year enrollment includes new entrants and those students repeating, reentering or continuing.

*U.S. Citizens redefined in 1981-82 and thereafter to include Permanent Residents.

Source: Fall Enrollment Survey, Association of American Medical Colleges, November 22, 1982.

Table A-1-4. TOTAL U.S. MEDICAL SCHOOL ENROLLMENT BY RACIAL/ETHNIC GROUP AND CITIZENSHIP*
1978-79 THROUGH 1982-83

Racial/Ethnic Group	1978-79		1979-80		1980-81		1981-82		1982-83	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
U.S. Citizens										
White	53,720	86.4	54,854	86.0	55,434	85.0	56,201	84.8	56,032	83.9
Underrepresented Minorities										
Black	3,357	5.7	3,627	5.8	3,708	5.7	3,884	5.9	3,869	5.8
American Indian or Alaskan Native	202	0.3	212	0.3	221	0.3	229	0.3	235	.4
Mexican American/ Chicano	882	1.4	964	1.5	951	1.5	1,040	1.6	1,071	1.6
Puerto Rican (Mainland)	277	0.4	283	0.4	329	0.5	350	0.5	369	.6
(Subtotal)	(4,898)	(7.8)	(5,086)	(8.0)	(5,209)	(8.0)	(5,503)	(8.3)	(5,544)	(8.3)
Other U.S. Students										
Asian or Pacific Islander	1,592	2.6	1,777	2.8	1,924	3.0	2,518	3.8	2,936	4.4
Puerto Rican (Commonwealth)	617	1.0	700	1.1	798	1.2	856	1.3	903	1.4
Other Hispanic	489	0.8	567	0.9	683	1.0	847	1.3	962	1.4
(Subtotal)	(2,698)	(4.4)	(3,044)	(4.8)	(3,405)	(5.2)	(4,221)	(6.4)	(4,801)	(7.2)
Unidentified	—	—	22	0.0	55	0.1	7	0.0	17	0.0
Foreign	897	1.4	794	1.2	1,086	1.7	366	0.5	354	0.5
Grand Total	62,213	100.0	63,800	100.0	65,189	100.0	66,298	100.0	66,748	100.0

*U.S. Citizens redefined in 1981-82 and thereafter to include Permanent Residents.

Source: Fall Enrollment Survey, Association of American Medical Colleges, November 22, 1982.

Table A-1-9. APPLICANTS IN SCHOOLS OF OSTEOPATHIC MEDICINE IN THE UNITED STATES, BY SEX: ACADEMIC YEARS 1976-77 THROUGH 1982-83

Academic Year	Number of Applicants	Male	Female	Percent Female
1976-77	3,707	N/A	N/A	N/A
1977-78	3,918	3,359	559	14.5
1978-79	3,530	2,920	610	17.3
1979-80	3,856	3,091	765	19.8
1980-81	3,786	2,982	804	21.2
1981-82	3,885	2,984	901	23.2
1982-83	3,917	2,952	965	24.6

APPLICANTS IN SCHOOLS OF OSTEOPATHIC MEDICINE IN THE UNITED STATES, BY RACIAL/ETHNIC CATEGORY: ACADEMIC YEARS 1976 THROUGH 1982

Academic Year	Total Applicants	Minority Applicants	Black	Hispanic	American Indian	Asian	Percent Minority
1976-77	3,707	168	59	33	14	62	4.5
1977-78	3,918	220	111	42	12	55	5.6
1978-79	3,530	231	116	38	18	59	6.5
1979-80	3,856	312	113	56	19	104	8.1
1980-81	3,786	319	130	76	15	98	8.4
1981-82	3,885	362	138	92	15	117	9.3
1982-83	3,917	433	150	128	16	139	11.1

SOURCE: American Association of Colleges of Osteopathic Medicine, Annual Statistical Report, 1983. Data include colleges participating in the American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS).

Table A-1-10. FIRST-YEAR AND TOTAL ENROLLMENT AND GRADUATES IN SCHOOLS OF OSTEOPATHIC MEDICINE IN THE U.S., BY SEX, ENTERING YEAR 1968 THROUGH 1981

		FIRST-YEAR ENROLLMENT			TOTAL ENROLLMENT			GRADUATES		
Academic Year	Number of Schools	Total	Women	Percent Women	Total	Women	Percent Women	Total	Women	Percent Women
1968	5	521	21	4.0	1,879	53	2.8	427	8	1.9
1969	6	577	14	2.4	1,997	59	3.0	432	12	2.8
1970	7	623	17	2.7	2,151	61	2.8	472	11	2.3
1971	7	670	29	4.3	2,304	79	3.4	485	18	3.7
1972	7	810	56	6.9	2,579	116	4.5	649	18	2.8
1973	7	884	83	9.3	2,780	181	6.5	594	17	2.9
1974	9	974	106	10.9	3,139	267	8.5	702	44	6.3
1975	9	1,038	140	13.5	3,443	362	10.5	809	48	7.2
1976	10	1,088	179	16.5	3,671	472	12.9	908	84	9.3
1977	12	1,163	192	16.5	3,926	570	14.5	971	68	7.0
1978	14	1,322	222	16.8	4,221	688	16.3	1,004	163	16.2
1979	14	1,426	265	18.6	4,571	789	17.3	1,059	192	18.1
1980	15	1,496	329	22.0	4,940	971	19.7	1,151	202	17.6
1981	15	1,582	378	23.9	5,304	1,108	20.9	1,017*	186	18.3

SOURCE: American Association of Colleges of Osteopathic Medicine, Annual Statistical Report, 1983, page 14.

* Decline attributable to a changeover in one school from a 3-year to a 4-year curriculum.

Table A-1-11. FIRST-YEAR ENROLLMENT AND TOTAL ENROLLMENT IN SCHOOLS OF OSTEOPATHIC MEDICINE IN THE UNITED STATES BY RACIAL/ETHNIC CATEGORY: ENTERING YEARS 1976 THROUGH 1981

Entering Year	First Year Enrollment	First Year Minority Enrollment	Black	Hispanic	American Indian	Asian	Percent Minority
			Number of Students - First Year				
1976	1,088	59	26	12	6	15	5.4
1977	1,163	63	26	13	8	16	5.4
1978	1,322	74	31	17	10	16	5.6
1979	1,426	93	40	18	6	29	6.5
1980	1,496	99	40	18	8	33	6.6
1981	1,582	104	37	22	12	33	6.6

Entering Year	Total Enrollment	Total Minority	Black	Hispanic	American Indian	Asian	Percent Minority
1976	3,671	155	70	27	16	42	4.2
1977	3,926	173	76	33	19	45	4.4
1978	4,221	192	87	36	24	45	4.5
1979	4,571	241	100	45	26	70	5.3
1980	4,960	252	94	52	19	87	5.1
1981	5,304	301	104	62	26	109	5.7

SOURCE: American Association of Colleges of Osteopathic Medicine, Annual Statistical Report, 1983.

Table A-3-3. FIRST-YEAR ENROLLMENT IN SCHOOLS OF DENTISTRY IN THE UNITED STATES, BY SEX: ACADEMIC YEARS 1968-69 THROUGH 1982-83

Academic year	Both sexes	Male	Female
	Number of students		
1968-69	4,203	4,157	46
1969-70	4,355	4,299	56
1970-71	4,565	4,471	94
1971-72	4,745	4,598	147
1972-73	5,337	5,113	224
1973-74	5,445	5,054	391
1974-75	5,617	4,986	631
1975-76	5,763	5,056	707
1976-77	5,935	5,133	802
1977-78	5,954	5,074	880
1978-79	6,301	5,301	1,000
1979-80	6,132	5,056	1,076
1980-81	6,030	4,836	1,194
1981-82	5,855	4,587	1,268
1982-83	5,498	4,275	1,223
	Percent		
1968-69	100.0	98.9	1.1
1969-70	100.0	98.7	1.3
1970-71	100.0	97.9	2.1
1971-72	100.0	96.9	3.1
1972-73	100.0	95.8	4.2
1973-74	100.0	92.8	7.2
1974-75	100.0	88.8	11.2
1975-76	100.0	87.7	12.3
1976-77	100.0	86.5	13.5
1977-78	100.0	85.2	14.8
1978-79	100.0	84.1	15.9
1979-80	100.0	82.5	17.5
1980-81	100.0	80.2	19.8
1981-82	100.0	78.3	21.7
1982-83	100.0	77.8	22.2

SOURCE: American Dental Association, Council on Dental Education. *Annual Report on Dental Education, 1980-81 through 1982-83*, and *Trend Analysis: Supplement to the Annual Report on Dental Education*, for 1974-75 and for 1979-80.

Table A-3-4. NUMBER OF FIRST-YEAR DENTAL STUDENTS AND NUMBER OF DENTAL GRADUATES, BY SEX: PROJECTED FOR ACADEMIC YEARS, 1982-83 THROUGH 1999-2000[1]

Academic year	Number of first-year students			Number of graduates		
	Total	Male	Female	Total	Male	Female
1982-83[2]	5,498	4,275	1,223	5,667	4,677	990
1983-84	5,331	4,068	1,263	5,571	4,473	1,098
1984-85	5,171	3,868	1,303	5,410	4,243	1,167
1985-86	5,016	3,677	1,339	5,079	3,954	1,125
1986-87	4,865	3,493	1,372	4,925	3,763	1,162
1987-88	4,719	3,317	1,402	4,777	3,578	1,199
1988-89	4,719	3,317	1,402	4,633	3,401	1,232
1989-90	4,719	3,317	1,402	4,493	3,231	1,262
1990-91 through 1999-2000	4,719	3,317	1,402	4,358	3,068	1,290

[1] The basic methodology was used for all of these projections. It is assumed that the number of first-year students will continue to decrease during the next five years at about the same rate as during the last five years. Also, it is assumed that the proportion of female students will continue to increase at about the same rate as in the past.

[2] First-year students for 1982-83 are actual figures.

SOURCE: Health Resources and Services Administration, Bureau of Health Professions, Division of Associated and Dental Health Professions.

Table A-3-5. FIRST-YEAR ENROLLMENT IN SCHOOLS OF DENTISTRY IN THE UNITED STATES, BY RACIAL/ETHNIC CATEGORY: ACADEMIC YEARS 1971-72 THROUGH 1982-83 1/

Academic year	Total first-year enrollment	Racial/ethnic category First-year minority enrollment	Black	Hispanic	American Indian	Asian	Other minority
	Number of students						
1971-72	4,705	412	245	40	4	112	11
1972-73	5,287	475	266	56	5	138	10
1973-74	5,389	529	273	69	12	141	34
1974-75	5,555	551	279	75	12	142	43
1975-76	5,697	637	298	75	22	186	56
1976-77	5,869	645	290	96	19	174	66
1977-78	5,890	641	296	110	10	225	2/
1978-79	6,235	681	280	122	16	263	2/
1979-80	6,066	745	274	163	19	289	2/
1980-81	5,964	772	283	160	12	317	2/
1981-82	5,789	876	299	183	21	373	2/
1982-83	5,433	879	289	187	16	387	2/
	Percent						
1971-72	100.0	8.8	5.2	0.9	0.1	2.4	0.2
1972-73	100.0	9.0	5.0	1.1	0.1	2.6	0.2
1973-74	100.0	9.8	5.1	1.3	0.2	2.6	0.6
1974-75	100.0	9.9	5.0	1.4	0.2	2.6	0.8
1975-76	100.0	11.2	5.2	1.3	0.4	3.3	1.0
1976-77	100.0	11.0	4.9	1.6	0.3	3.0	1.1
1977-78	100.0	10.9	5.0	1.9	0.2	3.8	2/
1978-79	100.0	10.9	4.5	2.0	0.3	4.2	2/
1979-80	100.0	12.3	4.5	2.7	0.3	4.8	2/
1980-81	100.0	12.9	4.7	2.7	0.2	5.3	2/
1981-82	100.0	15.1	5.2	3.1	0.4	6.4	2/
1982-83	100.0	16.2	5.3	3.4	0.3	7.1	2/

1/ Excludes students at University of Puerto Rico.

2/ The category of "Other minority" was eliminated from first-year student data for 1977-78 and subsequent years.

SOURCE: American Dental Association, Council on Dental Education. Minority Student Enrollment and Opportunities in U.S. Dental Schools, for 1971-72 and for 1972-73. Minority Report; Supplement of Annual Report on Dental Education 1973-74, and reports for subsequent academic years.

Table B-1-7. FEDERAL AND NON-FEDERAL PHYSICIANS (MDs) BY SPECIALTY AND SEX, 1975 AND 1980

	1975			1980			Change 1975 to 1980	
Women Specialty	Number	Percent Of Women Physicians	Percent Of All Physicians	Number	Percent Of Women Physicians	Percent Of All Physicians	Number	Percent Of Women Physicians
Total Physicians	35,636	100.0	9.1	54,284	100.0	11.6	18,648	52.3
General Practice	2,866	8.0	5.3	4,677	8.6	7.8	1,811	63.2
Internal Medicine	4,533	12.7	6.7	8,930	16.5	9.9	4,397	97.0
Surgery	1,196	3.4	1.6	2,318	4.3	2.7	1,122	93.8
Pediatrics	5,244	14.7	23.1	8,314	15.3	28.2	3,070	58.5
Ob-Gyn	1,777	5.0	8.2	3,243	6.0	12.3	1,466	82.5
Radiology	1,006	2.8	6.2	1,742	3.2	8.6	736	73.2
Psychiatry	3,803	10.7	14.3	5,257	9.7	17.1	1,454	38.2
Anesthesiology	1,819	5.1	14.2	2,388	4.4	15.0	569	31.3
Other	4,984	14.0	11.4	7,837	14.4	13.8	2,853	57.2
Other Unspecified 1/	8,408	23.6	15.7	9,578	17.6	18.2	1,170	13.9

	1975			1980			Change 1975 to 1980	
Male Specialty	Number	Percent Of Male Physicians	Percent All Physicians	Number	Percent Of Male Physicians	Percent All Physicians	Number	Percent Of Male Physicians
Total Physicians	358,106	100.0	90.0	413,395	100.0	88.4	55,289	13.4
General Practice	51,691	14.4	94.7	55,372	11.8	92.2	3,681	6.6
Internal Medicine	65,163	18.2	93.3	81,703	17.5	90.1	16,540	20.2
Surgery	73,088	20.4	98.4	78,155	16.7	97.3	5,067	6.5
Pediatrics	17,468	4.9	76.9	21,148	4.5	71.8	3,680	17.4
Ob-Gyn	19,954	5.6	91.8	23,062	4.9	87.7	3,108	13.5
Radiology	15,234	4.3	93.8	18,540	4.0	91.4	3,306	17.8
Psychiatry	22,700	6.3	85.7	25,495	5.5	82.9	2,795	11.0
Anesthesiology	11,042	3.1	85.8	13,570	2.9	85.0	2,528	18.6
Other	38,692	10.8	88.6	49,165	10.5	86.2	10,473	21.3
Other Unspecified 1/	48,478	12.6	84.3	43,185	9.2	81.8	5,293	12.3

1/ - Includes inactive, unclassified and physicians whose address is unknown.

SOURCE: Compiled by Health Resources and Services Administration, Bureau of Health Professions, Division of Medicine, based on data from the American Medical Association. Physician Distribution and Medical Licensure in the U.S., 1976 and Physician Characteristics and Distribution in the U.S. 1981, Chicago.

SUMMARY OF HEALTH PROFESSIONS TRAINING ASSISTANCE ACT OF 1984

This bill reauthorizes current programs in Title VII of the Public Health Service Act for four years at funding levels consistent with FY 84 appropriations. The following is a summary of changes made in the statute:

1) Redefine "program for the training of physicians assistants" to focus on training primary health care providers and emphasize training in disease prevention, health promotion, geriatric medicine and home health care. (Sec. 701(8)(A))

2) Redefine "allied health professional" to include higher degree than the baccalaureate level. (Sec.701(10))

3) Include at least one representative of an allied health professions education program on the National Advisory Council on Health Professions Education. (Sec. 702)

4) Include acquisition of equipment or instrumentation under grant authority for construction of teaching facilities. (Sec. 721)

5) Maintain level of federal loan insurance program to a total principal amount not to exceed $250,000,000. (Sec. 728)

6) Include students enrolled in post baccalaureate program in allied health among those entitled to participate in federally insured loan programs. (Sec. 729)

7) Amend Health Education Assistance Loan Program in order to improve administration, collection rate, and allow the Student Loan Marketing Association to originate loans. (Sec. 734)

8) Amend the Health Professions Student Loan Program to improve its administration and collection rate, including changing a penalty for outstanding loans. (Sec. 741)

9) Limit funds from the new authority for Health Professions Student Loan Program to schools that have established such loan funds after July 1, 1972. (Sec. 742)

10) Give authority to the Secretary of HHS to use studnent loan funds from a school which closes, or has an excess cash balance, to capitalize student loan funds at another school in need of such funds. (Sec. 742)

11) Extend authority for the Health Professions Student Loan Program through 1991. (Sec. 743)

12)Amend authority for Area Health Education Programs to give them more flexibility.

13) Redefine dentistry to "advanced, educational program in general dentistry." (Sec. 786)

14) Amend project grant authority for interdisciplinary training and curriculum development to focus on current national health priorities, including: health promotion/disease prevention, training in geriatrics and long term care; promoting economics in health professions, teaching and practice; faculty development for health professional schools; and nutrition. Authorization level is increased to $6.0 million. (Sec. 788)

New Section:

15) Require a study be submitted October 1, 1985, regarding student indebtedness, and the association, if any, between level of indebtedness and specific careeer choices. This study will include recommendations for a national policy, if needed, to assure an appropriate distribution of medical specialists.

16) Repeal several sections which are obsolete or redundant, including:

-Advance Funding--Title VIII (Sec. 703) This authority has not been used for many years. "Advance funding" (appropriations of funds this year for obligation in a future year) is different from "forward funding" (appropriation and obligation of funds this year for expenditure by the recipient of the award next year).

-Lister Hill Scholarship Program (Sec. 759) This authority, added by the Health Professions Educational Assistance Act of 1976, never was implemented. It expired (for new awards) at the end of FY 1980.

-Part D - Grants to Provide Professional and Technical Training in the Field of Family Medicine (Sec.s 761 - 1st 768) This authority was never implemented. It expired at the end of FY 1973.

-Grants for Training, Traineeships, and Fellowships in Family Medicine (2nd Sec. 767) This authority expired at the end of FY 1977 and has been replaced by the family medicine training authority in Sec. 786.

-Grants for Support of Postgraduate Training Programs for Physicians and Dentists (2nd Sec. 768) This authority never was implemented and expired at the end of FY 1976.

-Grants for Training, Traineeships, and Fellowships for Health Professions Teaching Personnel (Sec. 769)

-Grants for Computer Technology Health Care Demonstration Programs (Sec. 769A) This authority expired at the end of FY 1977.

-General Provisions (Relating to Expired Secs. 767-769A) Sec. 769B) This section should be repealed with Secs. 767-769A.

-Capitation Grants (Sec. 770 -771) Repeal capitation grants for health profession schools with the exception of schools fo public health.

-Education of Returning U.S. Students from Foreign Medical Schools (Sec. 782) This authority expired at the end of FY 1980 and is no longer needed.

-Occupational Health Training and Education Centers (Sec. 785) This authority, which expired at the end of FY 1980, never was implemented as such. Similar training centers have been established under more general authorities administered by the National Institute for Occupational Safety and Health.

-Training in Emergency Medical Services (Sec. 789) This authority expired at the end of FY 1982 (per P.L. 96-142) Responsibility for EMS training is more appropriately assumed by State and local governments or other non-Federal entities.

Nurse Training Act Reauthorization

"Nurse Education Amendments of 1984"

I. Creation of a New Bureau of Nursing

A. General Authority - To create a Bureau of Nursing within the Health Resources and Services Administration. The Bureau will have three Divisions; the Division of Nurse Educational Support, the Center for Nursing Research, and the Division for Advanced Nurse Education.

1. Authority for the Bureau Director under the Secretary to carry out all of the programs within the bureau.

2. Authority to establish systems to collect, compile and analyze data on professional nursing and nurse education, and report annually to the Congress on nursing education and educational requirements.

B. Division of Nurse Educational Support

The Division will oversee - Financial Assistance to Nursing Students and Nursing Schools

1. Traineeships - Sec. 830 - is amended to read as follows; "grants to schools of nursing to cover the cost of traineeships for the educaton of master's and doctoral level nurses - (A) to prepare to practice as nurse practioners and nurse midwives, (B) to serve in and prepare for practice as nurse adminstrators, educators and nurse researchers; (C) or to serve in and prepare for practice in other professional nursing specialties determined by the Secretary to require advanced training."

2. Nurse Anesthetists - Sec. 831 is amended to read as follows: (b) The Secretary may also make grants to public or private non-profit institutions to cover the cost of projects to improve and upgrade existing programs for the training of registered nurses to be nurse anesthetists which are accredited by an entity or entities designated by the Secretary of Health and Human Services."

3. Student Loans Provisions

Sec. 836 - is amended to read as follows:

a. Delete preference to LPN's.

b. Grant Secretary authority to retain excess cash from school loan programs that have been terminated within the NSL program. These funds can then be recycled to newly accredited schools to start-up loan programs, existing schools with new loan programs and existing schools.

c. Extend authority granted federal agencies by the Debt Collection Act of 1982 to obtain addresses from IRS records to institutions who participate in the HPSL and NSL programs.

C. Center for Nursing Research

A. General authority to the Secretary to create a Center for Nursing Research. The purpose of the Center will be to conduct, support and disseminate basic and clinical research, training and related programs, through grants awarded on a competitive basis to qualified nurse researchers. The Center's activities will be oriented towards basic and applied scientific research related to the promotion of health, prevention of illness, and understanding human responses of individuals and families to acute and chronic illnesses, disabilities and the aging process.

2. The Secretary shall report biannually on the activities of the Center, the coordination of nursing research activities within the Center and with other government entities (both agencies and departments) and the status of nursing research.

D. Division of Advanced Nurse Education

1. Advanced Nurse Training - Sec. 821 is amended to read:

"(1) plan, develop and operate,

(2) expand; and

(3) maintain programs at the master's and doctoral degree level to prepare nurse educators, administrators, consultants, researchers or to serve as clinical nurse specialists or other professional nurse specialities as determined by the Secretary. ."

2. Nurse Practitioner Programs - Sec. 822 is amended to read:

"The Secretary may make grants to and enter into contracts with public and private collegiate schools of nursing to meet the costs of projects to:

"(1) plan, develop and operate,

(2) expand; and

(3) maintain programs for the education of nurse practitioners at the master's degree level, and accredited certificate programs for nurse midwives."

3. Special Projects - Section 820 - is amended to read as follows:

1. "(6) the Secretary may make grants and enter into contracts with public and private collegiate schools of nursing to carry out demonstrations with regard to: institutional and nursing service organizational frameworks that support more cost effective delivery systems and nursing education/practice collaborations."

II. Authorization Levels

A. Proposed Budget for the Nurse Education Amendments of 1984

	Proposed Authorization
Special Projects	$ 9 million-$7 million for grants and contracts and $2 million for demonstrations
Advanced Nurse Training	$11 million
Nurse Practitioners	$ 9 million
Traineeships	$ 9 million
Nurse Anesthetists	$400,000
Student Loans	$ 4 million
Start-up money for new Bureau	$ 2 million
Center for Nursing Research	$10 million
Total	$54,400,000

III. Repeals

A. Sections 801 through 805 (have not been funded since mi 1970's

B. Section 810 through 815 (have not been funded since mid 1970's

B. Section 815 (has not been funded for past 2 years)

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Deputy Director, Business Administration

February 29, 1984

Senator Orrin G. Hatch
135 Russell Senate Office Bldg.
U.S. Senate
Washington, D.C. 20510

Dear Senator Hatch:

On behalf of the American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, I want to commend your introduction of S.2311, a bill to amend the provisions of the Public Health Service Act relating to health maintenance organizations. You have certainly responded positively to the concerns about and opposition of the APA to the repeal of the requirement for mental health and substance abuse treatment in an HMO's basic health services (set forth in our April 8, 1983 letter).

We have previously testified against the discriminatory treatment of mental health, alcohol and drug abuse treatment by attempts to eliminate them from the "basic health services" and relegate them to supplemental. We are --as noted-- pleased that your reauthorization legislation continues current outpatient mental health, alcohol and drug abuse coverage at the level presently provided and applaud your efforts, Mr. Chairman, in this regard.

However, the inappropriate regulatory interpretation by the Carter Administration which resulted in inpatient psychiatric hospitals being deemed a supplemental, not basic health service is regrettably being continued.

On October 31, 1980, notwithstanding the clear legislative mandate to the contrary, Secretary Harris approved final regulations which eliminated inpatient psychiatric care from the basic health services requirement for HMOs. Secretary Harris disregarded the general provision in Section 1302(1)(B) of the Public Health Service Act which states, "The term 'basic health services' means inpatient and outpatient hospital services." She relied upon the provision defining the term 'supplemental health service' under paragraph (1)(D). However, paragraph (1)(D) refers to "short-term (not to exceed twenty visits) outpatient evaluation and crisis intervention mental health services," and not to inpatient hospital services, which are required under paragraph (1)(B).

In lieu of an amendment to reinstate the original Congressional intent we believe appropriate legislative intervention can be achieved through the committee report clarifying that inpatient psychiatric hospitalization is a basic health service under HMO law. The best evidence of the reality of inpatient psychiatric hospitalization as a basic service is the preliminary results from the 1982 National Survey of Psychiatric Services and Coverage Benefits within Health Maintenance Organizations. You may be interested to know that without regard to the inappropriate regulatory interpretation those preliminary survey results indicate that 33.33 percent of the surveyed HMOs provide psychiatric inpatient hospital coverage of 31 or more days; 57.07 percent at least 30 days.

The treatment of mental illness is insurable. Look at the FEHBP experience. When Aetna altered its benefit for the treatment of emotional disorders, Blue-Cross-Blue Shield, which had better benefits, enlarged its enrollment, since the benefit was desirable. Premiums did not skyrocket. Many studies have now been done which measure the reduction in medical-surgical utilization when a mental health service or benefit is introduced. These studies provide convincing evidence for inclusion of the treatment of emotional disorders in the basic health services to be provided by HMOs. In the mental health area, the introduction of mental health benefits at least pays for itself in reduced medical-surgical utilization. Two HMO based studies are most illustrative:

> --Kaiser Plan in California estimated that subsequent savings for each patient receiving psychiatric care were on the order of $250 per year. In a study which matched each of the 152 patients in the study group with a similar person who had a similar level of psychologic distress but who did not seek psychotherapy, the control group experienced virtually no change in health care utilization over the next five years. On the other hand, the study group, the group receiving psychiatric care, reduced its non-psychiatric outpatient visits by 62 percent and its inpatient days by 68 percent;
>
> --Group Health Association of Washington has found that patients treated by mental health providers reduced non-psychiatric physician usage with the HMO by 30.7 percent in the year after referral for mental health care was made available compared to the previous year. Furthermore, laboratory and x-ray services declined by 29.08 percent.

Outside the HMO arena, equally compelling data are to be found:

> --Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for all medical services was more than halved -- dropping from $16.47 to $7.06.
>
> --In Texas, a longitudinal study (1973-1977) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of over-65 patients in patient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than $1.1 million.

Further, there is preliminary research findings from GHA of Washington which suggest that appropriate and available psychiatric intervention to a single member of a family in need of such care has a positive cost-benefit upon the medical utilization by the entire family. For example, a hypochondriacal mother, once provided with psychiatric care, not only seeks treatment for her own physical disorders on a reduced basis, but takes her child less frequently to the pediatrician for minor complaints. Her spouse is similarly subjected to fewer medical interventions.

In the area of alcoholism treatment the evidence is overwhelming that the provision of treatment reduces medical and surgical utilization to a level which allows the alcoholism treatment to more than pay for itself.

In each case, whether treatment for an emotional disorder, or for alcoholism, or for drug abuse, it is important to recognize that what is being provided is appropriate care, not a palliative remedy. We could, for example, simply treat the liver problems of an alcoholic or the physical manifestations of a psychosomatic illness in an emotionally disturbed person. Such treatments are not only obviously less appropriate, but probably, in the long term, also more expensive, both in human and economic terms.

The omission of inpatient psychiatric treatment fosters the failure to perform a differential diagnosis to separate the illness with a psychiatric etiology from that with a physical etiology. Also, it encourages an inappropriate, incomplete or inaccurate diagnosis to hospitalize a patient (using a physical illness to permit inpatient psychiatric treatment) which ultimately is more costly.

The American Medical Association in testimony to the Subcommittee on Health and Environment of the Energy and Commerce Committee regarding HMO amendments and reimbursement of HMOs under Medicare stated: "We believe that the removal of mental health and alcohol and drug abuse services from the definition of 'basic health services' detracts from the identity of the HMO as providing a comprehensive package of health services regardless of a member's health status." The AMA has long called for parity of coverage for mental health services with that provided for other medical problems. The stigma still attached to emotional, nervous and mental disorders together with the cost effectiveness studies both provide convincing evidence for the inclusion of the treatment of mental illness in HMO basic health services.

We appreciate the opportunity of having our views included in the hearing record for S.2311.

Sincerely,

Melvin Sabshin, M.D.

Melvin Sabshin, M.D.
Medical Director

enclosure

American
Psychiatric
Association

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March 26, 1984

Senator Orrin G. Hatch
135 Russell Senate Office Bldg.
U.S. Senate
Washington, D.C. 20510

Dear Senator Hatch:

The American Psychiatric Association (APA), a medical specialty society representing over 29,000 psychiatrists nationwide, takes this opportunity to submit its comments concerning S.2303, a bill to revise and extend the Alcohol and Drug Abuse and Mental Health Services Block grant. The APA supports the Chairman's bill reauthorizing the ADM Block grant but would like to address particular areas of concern:

First, the proposed authorization levels of S.2303 allow for only a 9% growth increase which we believe would not only make it difficult to maintain the current service levels but would also prohibit services to be extended to unserved areas or expanded to meet unmet needs.

Therefore, we urge the Committee to increase appropriately the bill's authorization levels.

Second, we disagree with placing the administration of the health block grants in the Office of the Assistant Secretary for Health. We believe that the ADM block grant program should remain at the administrative level most experienced with these activities. It is only in this way that we can be assured that the appropriate Federal oversight will be maintained. The Alcohol, Drug Abuse and Mental Health Administration is appropriately regarded as the focal point for relating to the provision of these services nationwide and we urge it to continue.

Third, we support the proposed addition to the ADM block grant concerning the development of the model criteria and forms for the collection of data and information with respect to services provided.

Finally, we urge the Committee to consider amending S.2303 as proposed in H.R. 4330, a bill introduced by Congressman McKinney or with a comparable provision. That bill would amend section 1915(c) of the Public Health Service Act (the provision respecting the state's application for funding allotment) to clarify that the meaning of "least restrictive setting" is for care to be provided in the "optimum therapeutic setting." "Optimum therapeutic setting" is defined as "the environment that is least restrictive of an individual's personal liberty and where the care, treatment, habilitation, or rehabilitation is particularly suited to the level of services necessary to properly implement an individual's treatment, habilitation, and rehabilitation." Thus a state assures that the mentally ill are provided mental health treatment and related support services and not discharged inappropriately into a community unable to deal with his or her needs. It makes clear that where the available community services fail to provide conditions which enhance the care, treatment, and general well being of the individual an optimum therapeutic setting for an individual may be a properly operated State hospital or other care facility.

This concludes our statement and we appreciate having the opportunity to share our views.

Sincerely,

Melvin Sabshin M.D.

Melvin Sabshin, M.D.
Medical Director

MS/yh

STATEMENT OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

S. 2311
HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1984

SUBMITTED TO
THE COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

MARCH 1, 1984

The Blue Cross and Blue Shield Association, on behalf of its Member Plans, welcomes this opportunity to provide comments on amendments to the federal HMO Act.

Our own investment in HMOs has a long history and the results have been quite encouraging. Prior to enactment of the federal law, we were involved in 12 HMOs. Today, 40 Blue Cross and Blue Shield Plans own, operate or administer 59 HMOs, offering more programs in more areas of the country than any other HMO developer. Our Plans also provide contractual services to more than 20 other programs.

In addition to our breadth of coverage, we have seen a rapid increase in HMO enrollment, 23% growth in the twelve month period ending June 30, 1983. Preliminary enrollment figures for December 1, 1983 indicate more than 1.4 million members.

We are committed to the principles embodied in the HMO concept — managed care, prepayment and capitation with the HMO organization at risk. With some further modification of the federal HMO Act we believe that we could and would see an even faster development of this important concept.

When the 1973 federal law was enacted, it was intended to be a vehicle for the investment of public funds for the purpose of accelerating HMO development. While most of the Act was devoted to the responsible disbursement of funds, it was felt necessary to define eligible organizations in terms of their structure, benefits and conduct. The dual choice mandate was added to facilitate Congress' intent to test the effect of HMOs, and this mandated stimulated interest on the part of organizations like ours which had developed HMOs with private funds. When an employer is required by law to offer federally qualified HMOs, non-qualified HMOs, regardless of their merits, are at a distinct disadvantage. Fifty-five percent of the employers responding to a recent Hay Associates survey reported policies that limited HMO offerings to federally qualified HMOs. Thus the marketplace is increasingly demanding the federal qualification of HMOs.

Two federally mandated requirements for qualification seem to us both inappropriate and counterproductive in today's market:

(1) The need for an HMO to be a separate legal entity with one-third of its governing board comprised of HMO enrollees, and

(2) The community rating requirement.

Of our 59 HMOs, 27 or 46% are federally qualified, up from 26% two years ago. We are responding to market demand. However, if these two requirements were removed, we believe that more Blue Cross and Blue Shield Plans (and no doubt other third parties) would find it both easier to develop more HMOs, and to offer them to a much wider spectrum of employee groups. The remainder of this statement will focus on these two requirements and the need for their repeal.

HMO Structure

The HMO Act requires a qualified HMO to have a governing board of which one third are HMO enrollees. This requirement is probably reasonable for organizations developed only as HMOs, especially if their development is publicly funded through federal grants, loans and loan guarantees under the Act. For health service benefit plans (or insurance carriers), however, whose boards already have responsibilities to all their subscribers (or to their stockholders) and whose HMOs are developed with private funds, this requirement is not reasonable.

Should an insurance carrier or service benefit plan manage to comply with the board composition requirement and itself become a federally qualified HMO, the Act and regulations governing the activities of the HMO would preclude it from offering its traditional health benefits — i.e., another choice for consumers — in areas where HMO benefits are offered. This prohibition derives from the federal regulations that require that the plan or carrier not offer a lessor scope of benefits than its HMO offering. Thus, the practical effect of these provisions is to require the creation of an HMO corporation, separate from its sponsoring organization, to achieve federal qualification.

In our view, a separate HMO legal entity: (1) is unnecessarily costly, requiring a wasteful expenditure of health care dollars for incorporation, capitalization and licensure; and (2) can hinder private investment and resource management by precisely those organizations which are best equipped by experiences and resources to develop successful HMOs.

To accomplish this, we:

(1) Strongly support elimination of the requirement for enrollee representation on an HMO's governing board as proposed by S. 2311; and

(2) Propose in addition an amendment which would state that HMO law and regulations apply only to a sponsoring organization's HMO business and not to the offering of other health benefits by that organization. We would be pleased to work with the Committee on language changes which would accomplish this.

HMO Rating Methodology

HMOs compete for members on two levels, the employer or group level and the employee or individual level. On the employer level, market entry is facilitated by existence of the dual choice mandate. On the employee level, however, the difference between the cost of the HMO program and the alternative traditional health benefits plan becomes a key determinant of the competitiveness of the HMOs.

Under the HMO Act, employers are required to contribute the same amount toward the federally qualified HMO's premium as is contributed toward the traditional health benefits plan, unless that contribution would exceed the cost of the HMO's premium. If the HMO premium is greater than the employer's contribution, the additional cost must be paid by the employee joining the HMO.

In nearly all large employee groups, premiums for traditional coverage are based upon the historic claims experience of the particular group. Such "experience rating" has proven to be the most reliable in projecting future utilization and cost experience. High cost groups pay higher premiums and low cost groups pay lower premiums for traditional coverage.

Community-rated HMOs, however, must base their premiums on the average costs of their total membership. They are unable to reflect the actual historic costs of a particular group of employees in the premiums for that group. This creates no problem in employee groups whose experience is roughly similar to the cross-section of the surrounding community enrolled by the HMOs. In such settings, the federally qualified HMOs can be quite competitive.

Even in those situations, however, some employers may want no part of community-rated products, particularly employers who have decided to invest in employee health promotion or illness prevention programs, in order to reduce the overall costs of their health benefits. If such programs are effective, the employer is likely to want the benefits to be reflected in his subsequent (experience based) rates and not 'dissipated' across other groups through community rating.

The more common, and more difficult problem, however, arises in employee groups whose experience differs widely from the average, either on the low side or the high side. The HMO puts itself at significant risk by offering its services to such groups. In a low cost group, the employer's contribution to the HMO will be low and the employee's contribution will be correspondingly high. Only those who anticipate use of comprehensive HMO benefits are likely to pay the additional cost. In a high cost group, where the HMO premium differential is low or non-existent and HMO benefits are broader than under the traditional plan, the HMO option may be attractive to many. The cost of delivering services to this group, however, may exceed the HMO's community-rated premiums. In either case, the HMO will be attracting relatively high risk enrollees (commonly referred to as "adverse selection"), and their resulting experience will typically increase the HMOs' community rated premiums.

The unfortunate result is that HMOs have little incentive to offer their services to groups which fall outside the narrow range of the community rates which HMOs are allowed to charge. This restricts an HMO's market and limits the areas within which the cost containment characteristics of an HMO can be brought to bear.

The 1981 HMO Amendments brought greater flexibility to HMOs by permitting community rating by classes — age, sex and family size, for example. This was helpful; it did allow some recognition of the need for HMOs to experience rate. However, this flexibility is not enough for HMOs to be competitive in the low cost markets and avoid adverse selection in the high cost markets.

In light of the above, we:

(1) Support the proposal in S. 2311 which would allow HMOs flexibility in setting rates for supplemental benefits; and

(2) Urge extension of the same flexibility to basic HMO benefits.

In summary, we support provisions of S. 2311 which would remove the board composition requirement and allow flexibility in rating supplemental benefits. In addition, we urge (1) addition of an amendment which states that HMO law and regulations apply only to HMO business, not to the offering of other health benefits by a sponsoring organization, and (2) removal of the community rating requirement for all HMO benefits.

We appreciate this opportunity to comment and stand ready to discuss our views in greater detail if requested.

AVMED HEALTH PLAN

9400 SO. DADELAND BOULEVARD, SUITE 200, MIAMI, FLORIDA 33156 • DADE (305) 665-5437 BROWARD (305) 462-9520

Herbert H. Davis, M.D.
Chairman

March 28, 1984

The Honorable Oren Hatch
Senate Human Resources Committee
Dirkson Senate Office Building
Washington, DC 20510

Dear Senator Hatch:

I would like to suggest certain changes in the HMO bill with regard to the deletion of community rating and supplementary benefits. The definition as to what basic and supplementary benefits are has received little consideration by OHMO. They simply take the attitude that there can be no limit to basic benefits and include within that framework such things as: persons injured while they are committing a felony, intentionally self inflicted injury, and unlimited treatment for infertility (there is no reasonable end point to the "medically necessary" treatment of infertility and therefore treatment for this condition is frequently abused). The same applies to treatment for obesity, and most importantly, the entire subject of neonatal intensive care.

Normal newborn care obviously falls within the definition of basic benefits. Neonatal intensive care does not. It is frequently experimental in nature and sometimes involves the transfer of an infant to an out of area location because of lack of availability of local treatment facilities. Thus, it could theoretically be excluded from coverage because most HMO's only cover out-of-area if the event actually occurs out-of-area. Furthermore the care provided falls outside the scope of the control of the HMO in most cases. A reasonable solution to this problem is to label neonatal ICU treatment as a supplemental rather than a basic benefit so that the cost for such treatment can

Cont'd....

AV-MED
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be mitigated through appropriate mechanisms, and out-of-area coverage which is usually denied, can be provided.

All of the above mentioned conditions, if placed in the supplemental rather than the basic benefit category, would be of immeasurable help to the HMO industry. I hope you will give this your careful consideration.

Yours truly,

AV-MED HEALTH PLAN

Herbert H. Davis, M.D.

HHD/hm

THE U.S.
CONGRESS

- MENTAL HEALTH
- MENTAL RETARDATION

March 4, 1984

NASMHPD POSITION ON S.2303, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT REAUTHORIZATION

SUBMITTED TO THE

U. S. SENATE COMMITTEE
ON LABOR AND HUMAN RESOURES

Harry C. Schnibbe
Executive Director

Stacey L. Crane
Program Administrator

1001 Third St., S. W., Washington, D. C. 20024 Phone 554-7807

NATIONAL ASSOCIATION STATE MENTAL HEALTH PROGRAM DIRECTORS

STATEMENT BY
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

NASMHPD Representative:	Terry Sarazin, Director Mental Health Program Divison State of Minnesota and Chairman, NASMHPD Committee on Financing of Mental Health Services

The National Association of State Mental Health Program Directors (NASMHPD) is an organization of 54 state and territorial mental health agencies.

NASMHPD functions under a cooperating agreement with the National Governors Association and all national policy for the 54 states and territories is developed in cooperation with the NGA.

NASMHPD ADDRESSES IN THIS STATEMENT THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT REAUTHORIZATION BILL (S.2303)

The budget for services to mentally ill persons by the state mental health agencies total seven billion dollars in 1984.

Although the mental health portion of the Federal ADM Block Grant represents only 3.25 percent of the total mental health effort of the 54 states and territories it is not to be considered an insignificant factor in the delivery of services ($227 million out of $7 billion).

The committee may be interested to know, that in 20 states the ADM Federal Block Grant is so critical that it represents between 19.2% and 168.5% of the state effort in funding community MH services:

Virginia	19.29%
Ohio	19.49%
Illinois	20.01%
South Carolina	20.54%
Nebraska	25.95%
Arkansas	27.78%
Vermont	28.62%
Oklahoma	28.99%
Maine	31.05%
New Mexico	32.52%
Tennessee	33.20%
Arizona	39.57%
New Hampshire	43.81%
Kansas	44.39%
Rhode Island	48.83%
Alabama	51.65%
Indiana	52.60%
Georgia	71.31%
South Dakota	90.54%
Mississippi	168.49%

Thus it may be seen that Federal Block Grant, in many states, is a substantial and critical underpinning of mental health services at the local level.

In all states it is an incentive to sustain and expand the shift of treatment focus of care of the mentally ill from institutions to the community.

The state mental health agencies operate and/or fund a wide variety of programs, services and facilities numbering over 12,000: psychiatric hospitals, residential facilities for children, geriatric centers, community mental health centers crisis intervention programs, case management systems, outpatient clinics, child guidance systems, day treatment facilies, surgical/medical hospitals, group homes, sheltered workshops, skilled nursing facilities, veterans homes, rehabilitation units, half-way houses, forensic insitititions, psychiatric services in prisons.

These programs have a long state government tradition behind them and mandate a heavy commitment of funds by Governors' budgets and legislative appropriations.

But, continuing support and expanding care at the community level demands new and fresh resources. Such incentive funding often is not readily available at adequate levels from state government or local government or private insurance sources.

The federal mental health block grant fills this critical need, and is a vital incentive to better care of the seriously mentally ill by the states.

The block grant, totally focused on community services, reinforces, strengthens and encourages the state and local effort to build stronger, broader and more effective *community* mental health service programs.

The *loss* or *reduction* of the block grant would be a critical blow to community mental health services in the states. At the same time recent history shows that, an expansion of funding under the block grant *drastically accelerates* state and local input and expansion of resources and services.

In terms of interest of the state governments and local governments in the provision of expanded, and better, mental health services at the community level it is essential that in FY 1985, and coming years, the ADM block grant grow at a reasonable but progressive rate.

It is in this sense that a true and effective federal/state/local partnership in delivery of mental health services at the community level can be achieved.

Authorizations for the ADM Block Grant for its early years were:

FY 1982 - $491 million
1983 - 511 " "
1984 - 532 " "

The state mental health directors respectfully recommend that in order to keep pace with inflationary rates, plus an appropriate and moderate growth rate the authorization levels of grants to the states be increased to:

FY 1985 - $566 million (9% over the Congressionally
1986 - 601 " authorized 1984 amount)
1987 - 636 "

If these sums were to be authorized by the Congress (and actually appropriated) it would mean that in the Fiscal Year 1985 the United States Government would have re-targeted its commitment and concern for community mental health services from 3.25 percent to 3.7 percent of the 54- state government investment in community mental health services.

The State Mental Health Directors further recommend:

(1.) The State Mental Health Directors would support the change of the audit proposed at Line 20 page 4 of S.2303.

(2.) NASMHPD would support the proposal in S. 2303 on data collection contained at line 23, page 4, thru line 6 of page 5 of S.2303, and we would urge that such data collection be done by state government and local organizations, under contract with the Federal Government.

(3.) NASMHPD would support the proposal in S.2303 for an HHS review of allocation of funds, to be reported prior to April 1, 1985, line 23, page 2 of S.2303, thru Line 18 of Page 3, providing that NASMHPD and NGA are involved in the deliberations. There should be no redistribution of funds until the study is completed and reviewed by NGA and NASMHPD.

(4.) NASMHPD would support the proposal in S. 2303 on line 9 of page 2 in regard the Secretary of HHS witholding one percent for re-training.

(5.) NASMHPD would support the amendment in S. 2303 proposed at line 8 of page 5, repealing the "Recommendations to the Congress" by October 1, 1983

(6.) NASMHPD will object to any provisions added to the block grant that reduce the flexibility of the state agencies in assignment of federal block grant dollars to local services.

NASMHPD calls to the attention of the Congress that in some states the federal block grant dollars represent .41% of the states total mental health effort. If you increase the appropriation for the ADM block grant by $10,000,000 in FY 1985 the state with the .41% mental health share will recieve an additonal $9,319. NASMHPD urges you to keep this in mind when you consider adding "mandates" to the states in delivery of services to mentally ill in the community. Envision yourselves as the Governor, Legislature or Mental Health Agency in a state that is given an additional $9,319 with a half-dozen new "strings - attached" on how the money must be expended.

The block grant is only 3.25%, at present, of the mental health effort of the 54 states & territories. We urge you to keep it flexible for the states' to use it as an incentive as best suits the states' plans for community mental health services.

(7.) Mr. Chairman, only a handful of federally funded CMHC's exist that would have had 8 years of federal funding thru 1985 under the old "CMHC Act". The state agencies intend to provide funding to these programs thru their 8th year. We have no objection to provisions that would assure this. The states plan no phase - out of these services in as much as in most states they are an essential core of the local services.

(8.) NASMHPD does not favor any "demonstration" projects funded out of the block grant. Such demonstrations, if considered by this Committee, should be in addition to the block grant and not allocated on the block grant formula basis.

(9.) NASMHPD, as in the past, supports federal funding for "Community Support Programs", providing they are funded outside the ADM block grant.

SUMMARY

Mr. Chairman, the state mental health agencies warmly support the three-year extension of the *federal* block grant providing support for the massive and intensive effort of the state mental health agencies to provide comprehnsive mental health services at the community level.

Although the federal government involvement in the community mental health effort is only three percent of the state governement effort, that 3% is a vital and necessary incentive to reinforce the conviction of the states, counties and cities that the seriously mentally ill must be served at every opportunity in the community.

We welcome and encourage the small but growing partnership of the federal government in this critical effort.

Mr. Chairman, we appreciate your courtesy in hearing the state governments on this issue, which is of substantial importance to the community mental health effort in this nation.

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ATLANTIC EMERGENCY MEDICAL SERVICES COUNCIL, INC.
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Washington, D. C. 20004
(202) 393-1313

March 15, 1984

The Honorable Orrin G. Hatch
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

On behalf of the Atlantic Emergency Medical Services Council, Inc., I want to submit comments for the record to the Committee on Labor and Human Resources regarding reauthorization of the Emergency Medical Services program in the Preventive Health and Health Services Block Grant. The Atlantic EMS Council encompasses the states of Maryland, Delaware, Pennsylvania, Virginia, West Virginia, New York, New Jersey, and the City of Washington, D. C. Its purpose is to foster a complete, compatible and integrated network of emergency medical services systems throughout the mid-Atlantic region. The Council strongly supports increased targeted funding for emergency medical services, either through separate categorical funding or with a special earmarking in the block grant. Mr. Chairman, EMS deserves special attention, but unfortunately is receiving short shrift in the current Preventive Health and Health Services Block Grant.

EMS is primarily concerned with critically ill and injured victims of trauma. When an adequate and properly coordinated system of EMS is in place, survivability of trauma victims increases dramatically. Despite this fact, a recent General Accounting Office Report reviewing state implementation of the Preventive Health and Health Services Block Grant stated that the percentage of total expenditures for emergency medical services decreased by more than one percent in eight of the 13 states surveyed. The report goes on to point out that of these eight states, two had discontinued funding for EMS "because state officials believed it to be a local responsibility."

Provision of EMS is not solely a local issue. Traditional geographic and political boundaries are irrelevant in most cases. Systems must cover

The Honorable Orrin G. Hatch
March 15, 1984
Page Two

broad areas rather than small localities because victims may require the services of a variety of specialized facilities, such as a shock-trauma center, a burn unit or a pediatric emergency facility. Every locality cannot afford to have a major trauma center. There must be a renewed Federal commitment to supporting the EMS program if we are to realize its full potential.

We also believe that current restrictions on using Preventive Health and Health Services Block Grant funds for operational costs or the purchase of equipment have unnecessarily hampered development of EMS systems. The GAO stated that the restriction on the purchase of equipment was often cited by state officials as being a contributing factor to decreased expenditures. This was especially true because communications equipment was a substantial expense under the old categorical program. These restrictions should be removed.

Articles such as that appearing in the March 1984 issue of WASHINGTONIAN MAGAZINE are increasing public awareness of the extraordinary efficacy of emergency medical services systems. However, we will not be able to meet the increased expectation of citizens if these systems are not permitted to develop and mature.

Thank you for providing us with the opportunity to make these observations. Please contact us if we can provide any additional information.

Sincerely,

Harry Teter, Jr.
Director

HTjr:a

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Mr. James W. Powell
Editor
Committee on Labor and Human Resources
United States Senate
430 Dirksen Building
Washington, D.C. 20510

Dear Mr. Powell:

Enclosed is the edited transcript of Dr. Edward N. Brandt, Jr., Assistant Secretary for Health, and other Public Health Service representatives from the March 22 Committee hearing. Also enclosed are responses to questions submitted for the record.

Please let me know if we can be of further assistance.

Sincerely yours,

Cynthia C Root

Cynthia C. Root
Deputy Assistant Secretary
for Legislation (Health)

Enclosures

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SENATOR KENNEDY

1. Q Do you regard alcoholism, drug abuse, mental health, disease prevention and health promotion, and community health services as areas of National concern and responsibility? On what basis do you believe that block grants lacking even standarized reporting requirements are the best vehicle for achieving these goals?

A There exist various areas of national concern which include alcoholism, drug abuse, mental health, disease prevention and health promotion, and community health services. Under the health block grants, the States are responsible for identifying their health needs and for developing a program to address these needs. block grants are an appropriate vehicle for providing resources to the States so that they can design and implement health programs and appropriate information requirements to address their specific health needs. For example: (1) A State's plan for the expenditure of these funds must be made available for public view as part of the application process; (2) there are compliance reviews in several States each year which allow us to observe the State's adherence to various statutes and regulations; and (3) the legislative bodies in each State are involved in the application development process.

SENATOR KENNEDY

2. Q Is it true that the Administration has not collected comparable, quantitative data which would allow assessment of the contribution of the current block grants to meeting national needs, either in terms of overall service levels or in terms of relative effectiveness of State programs in meeting these needs?

A It is true that we have not collected, on a uniform basis, quantitative data for the assessment of the impact of block grants towards meeting national needs either in service levels or State program effectiveness. In implementing the block grants, it has been our policy to eliminate burdensome requirements, including data collection requirements. The States will collect the data necessary for their own needs. At least two sample studies of multiple States, one by the General Accounting Office and one performed by the Urban Institute under contract with this Department, suggest there have not been major changes in operations by States as they have moved from the categorical programs to the block grant programs. We feel the States are capable of determining where the service needs are the greatest and where to place their dollars. In adequately meeting the needs of their population, the States will, in the process, contribute to the national need.

SENATOR KENNEDY

3. Q Has the Administration collected data on:
    - -- number of clients served, by State and program
    - -- services provided per client, by type of service and by State
    - -- number of clients served as a proportion of a standard definition of need, by State?

A We collect from the States data which the statutes require that the States submit. In implementing the block grants, we have given the States maximum flexibility and reduced a number of burdens, including data collection and submission.

The attached table displays the State reporting requirements contained in the health block grant statutes.

The table below displays the State reporting requirements contained in the Statute for PH&HS, ADMS, MCH and PC block grants:

STATE REPORTING REQUIREMENT	PREVENTIVE HEALTH & HEALTH SERVICES	ALCOHOL & DRUG ABUSE & MENTAL HEALTH SERVICES	MATERNAL AND CHILD HEALTH SERVICES	PRIMARY CARE
Application Reports	x	x	x	x
a. Programs & activities to be supported	x	x		x
b. Services to be provided	x	x	x	
c. Statement of Goals & objectives	x	x	x	
d. How State met previous year's goals	x	x		
e. Population areas & localities needing services			x	
f. Data State will collect			x	
Annual Report on Activities	x	x	x	x
a. Funds expended in accordance with application	x	x	x	x
b. Description of State Activities	x	x	x	x
c. Record of purposes for which funds spent	x	x	x	x
Annual Independent Audit	x	x		x
Independent Audit - every 2 years			x	

SENATOR KENNEDY

4. Q Without data of this type, how can the Administration justify either the funding levels it has proposed or continuation or expansion of the current blocks?

A The data that are collected allow each State to: (1) determine its needs and priorities; (2) develop programs to meet these needs and priorities; and (3) evaluate the programs the State administers. As you may recall, there have been several studies conducted on the States' implementation of block grants. The GAO studies have shown that States favor the concept of block grants and that, for the health block grants, States have implemented these grants with few problems. The success of the current health blocks is demonstrated in each of the 57 States and Territories which have implemented the block grants.

SENATOR KENNEDY

5.	Q	Would you object to a legislative requirement for collection of this type of data?
	A	We continue to believe the responsibility for the management of these programs belongs in the hands of the State officials who are charged with responding to the needs of their constituents.

SENATOR KENNEDY

6. Q The block grants were supposed to encourage States to meet Federal, State and private funds into a comprehensive approach to dealing with the Nation's health problems. What evidence is there that this has occurred? What revisions in the legislation would you recommend to further this objective?

A Within the federally prescribed funding requirements, States have the flexibility, within certain parameters, to move the money from their State programs to complement other sources of funds, either State, local or nongovernmental sources. These total funds then are directed towards those areas of greatest need as determined by the States which in the aggregate are the nation's health problems.

SENATOR KENNEDY

7. Q Would you object to including a planning requirement as a condition of receiving the block grants that would require a strategy to assess need in a standardized way and show how combined Federal, State, local and private funding will contribute to meeting National health objectives in the areas covered by each block?

A The current legislation for each health block grant requires the States to submit certain materials prior to receiving a block grant award. These materials include some items which relate to "planning requirements." The table at question 3 summarizes these application materials. In addition, the States are to conduct legislative public hearings on the proposed uses of the block grant funds prior to receiving a block grant award. We believe that such "planning requirements" contained in the current legislation are sufficient.

SENATOR KENNEDY

8. Q Secretary Brandt's introduction to Prevention '82 states "The time has come for us to turn our attention as a nation to the preservation of good health . . . . A strong National health promotion strategy requires the commitment and full participation of promoting health professionals, voluntary organizations, business and industry, organized labor, community leaders, and educators, and concerned citizens from every sector and level of our society. The appropriate role of the Federal Government is to lead, catalyze, and provide strategic support . . . ." The Surgeon General's 1980 report, Healthy People, provided a set of specific national prevention goals in areas ranging from reducing risk factors for stroke and heart disease to flouridation of community water supplies. How does the current block grant structure contribute or detract from achievement of these goals? How can the block grant structure be revised to enhance the Federal Government's leadership and catalytic role? Would not a planning and reporting requirement tied to the Healthy People goals be useful?

A The current block grant structure permits States to direct the available funds to their areas of greatest need. This discretion to combine available resources from whatever sector and focus them on the greatest needs is precisely the goal of the block grant program, as currently structured.

The present structure of the health block grants overlays nicely with most of the national prevention goals. Many of these "prevention" programs are contained in the block grants and the States are provided with funds to use as they deem appropriate. It is not necessary to revise the block grant structure to enhance our leadership role.

The Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion) is coordinating the tracking of the Nation's achievement of the 1990 goals. The Association of State and Territorial Halth Officials (ASTHO) through its ongoing data system, is collecting data from the States on the achievement of these goals.

SENATOR KENNEDY

9. Q The treatment of the chronically mentally ill in America is a national disgrace. Some studies have indicated that up to 50 percent of the homeless population are chronically mentally ill. Over 600,000 mentally ill individuals are incarcerated every year. Still other members of this population undergo costly, repeated "revolving door" institutionalizations because of lack of adequate community support. States have put increasing emphasis on serving this population, but the effort is nowhere near proportionate to the need and is still far too heavily focused on institutional care. What is the Department doing to encourage comprehensive planning and effective targeting of State and Federal funds to meet this need?

A Section 1915 (c)(3) of the Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant legislation requires that State Community Mental Health Centers receiving block grant funds provide services to individuals residing in a defined geographic area, with special attention to the chronically mentally ill. By drawing the States' attention to this specific group of individuals and their needs and targeting block grant funds to the delivery of services, the Department is encouraging the States to meet their needs.

In addition, ADAMHA staff, in reviewing applications for block grant funds and annual reports, are checking to ensure that this population group is receiving the services. These documents from the States indicate that the States are in fact focusing greater attention to the needs of the chronically mentally ill. Finally, during the 24 State compliance reviews completed, special attention has been given to documentation of the delivery of services to the chronically mentally ill.

SENATOR KENNEDY

10. Q Would you object to including a planning requirement in the block grant funds to ensure coordination of State, Medicaid, and PHS funds into an effective program of care using the community support model?

A The philosophy of the New Federalism, which is incorporated in the Omnibus Budget Reconciliation Act of 1981 that created the Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant, is to allow individual States to administer the block grant funds in a manner which maximizes the utilization of funds in accordance with particular State needs while minimizing Federal requirements and interventions in the delivery of ADMS services. Any increase in Federal requirements or specific direction being applied to the States from the Federal level would be contrary to the basic tenets of New Federalism and to the interests of the States in maintaining flexibility in the management of these programs.

(See Answer to Question #7)

SENATOR KENNEDY

11. Q What is the Department doing to assure that the mental health needs of children and the elderly, widely recognized as underserved, are met through the block grant structure?

A The Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant encourages each State to utilize the funds for delivery of services in areas most underserved within the States. Each State develops an intended use plan for the delivery of ADMS services based upon a statewide needs assessment required by law. The intended use plan is subject to review and comment by citizens of the State as well as organizations concerned with the delivery of ADMS programs. If the State needs assessment indicates that the need for mental health services to children and the elderly is largely being unmet, the plan for the utilization of funds for the State should reflect that need. The plan may subsequently be adjusted to provide additional funds later on. Thus through design and implementation, all recognized underserved areas are provided the opportunity to receive increased funding.

SENATOR KENNEDY

12. Q What progress is being made under the block grant program to provide mental health services in currently unserved localities?

A The Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant requires each recipient to determine independently the needs of the State for ADMS services. This needs assessment must cover not only specific populations but also areas which are currently underserved within the State. The needs assessment is then translated into a plan for the intended use of ADMS block grant funds. This plan is available for review and comment by the citizens of the State, including representatives from specific locations within the State. The comments made on the intended use plan result in adjustments so that the underserved localities are provided an opportunity to receive additional funding where a specific need can be determined.

SENATOR KENNEDY

13. Q In view of the vast unmet needs in this area, how do you justify a funding request that is a decline in real terms?

A The Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant was never intended to provide total funding for all necessary alcohol and drug abuse and mental health service delivery within any particular State. It is a catalyst to focus States' attention upon their particular needs and provide a source of funds in keeping with past Federal funding under the categorical programs which it replaces while transferring the administrative responsibility to the States. The States' funding resources, which include State, local, and community funds, as well as other sources, have increased since the implementation of the block grant and are expected to continue to increase in the coming years. The request contained in the FY 85 President's Budget shows an increase in the amount of funds to be provided through the ADMS block grant program.

QUESTIONS FROM SENATOR CHARLES E. GRASSLEY

1. Q One of the statements submitted for the record today says that the community mental health centers do not serve the chronically mentally ill.

Does your information bear this out, or would you disagree with this assertion? If it is true, what should we do about it?

A Section 1915(c)(3) requires the State Community Mental Health Centers receiving Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant funds to provide services to individuals residing in a defined geographic area, with special attention to the chronically mentally ill. A review of the ADMS block grant applications indicates that each of the recipients intends to utilize ADMS block grant funds for provision of mental health services to the chronically mentally ill. A review of the annual reports received for FY 82 and FY 83 indicates that funds were spent and services provided at the State level for the chronically mentally ill. The State compliance reviews completed in 24 States indicate in some detail that the States are providing mental health services for the chronically mentally ill within the States. We believe that identification of the chronically mentally ill as requiring special attention has been accomplished under the ADMS block grant and that the States are responding to this requirement and providing the necessary services.

QUESTIONS ON THE PRIMARY CARE BLOCK GRANT

1. Q When the primary care block grant was created in 1981, critics alleged that States have little interest in the provision of primary care services. Whether or not this was true then, what evidence is there now that States have an interest?

A There is little direct evidence that additional States would prefer to administer the Primary Care block grant program as currently authorized. However, approximately 40 States have shown a growing interest in the operation of primary care programs by entering into Memoranda of Agreement with the Health Resources and Services Administration. These agreements provide the opportunity for cooperative Federal and State administration of the community health centers program through joint planning for distributing primary care funds and manpower, identifying needs, developing new centers and reviewing the performance of existing centers.

We are encouraged by the success of these Memoranda of Agreement, by favorable comments from Governors, and by the success of the other block grants, and we anticipate a much more favorable reaction to the Primary Care block concept.

PRIMARY CARE BLOCK GRANT

2. Q Why do you feel it is important to have States involved in primary care block grants?

A We feel the involvement of States in the community health centers (CHC) program is important. Increased State involvement has reinforced coordination of Federal program activities with State health department resources which in turn promotes the effective utilization of Federal and State funds and manpower in the development of delivery systems and the support of health services provided by those systems.

Community health centers are governed by community boards of directors with an awareness of unique local health needs. Increased State involvement in the CHC program has developed in many State health departments a growing sensitivity and awareness of individual communities' needs which is essential to the mission of the program.

3. Q Is it important to have State Governments more involved in the area designation process? If so, why? Does it have an effect on provision of services?

A There has been much discussion of State involvement in the process for designating Medically Underserved Areas and Health Manpower Shortage Areas. We believe that both State and local agencies with their different perspectives need to be involved in area designation processes. We feel these two perspectives tend to maximize the utilization of resources, target them to service delivery systems where there is significant need, and complement data available at the national level.

PRIMARY CARE BLOCK GRANT

4. Q Dr. Brandt, in your view, what aspects of the primary care block grant are barriers to State participation?

A In my view the major barriers are: the stringent matching requirements; the prohibition of use of block grant funds for State administrative costs; and the required adherence to CHC rules and regulations.

QUESTIONS ON THE PREVENTIVE HEALTH SERVICES BLOCK GRANT

1. Q Dr. Brandt, from your testimony it is apparent that you agree with most aspects of S. 2301, the Preventive Health Services block grant and support simple reauthorization of these effective public health programs. However, I am surprised that you did not comment on the new section related to Home and Community Based Care, targeted for elderly and disabled individuals at risk of institutionalization. Could you please comment on this new initiative?

A We presently have your proposed legislation for Home and Community Based Care under policy and budgetary review within the Department. There are many issues relating to the provision of home care to the elderly which must be resolved. We are hoping to obtain increased information about the cost and effectiveness of such care from the results of the home health services studies which were developed as required under the Orphan Drug Act. When the results of these studies are completed and reported to you as required by the statute, we will be in a better position to make decisions about the types of home health programs which are needed.

2. Q Dr. Brandt, I have been somewhat disappointed that studies I requested in P.L. 97-414, the Orphan Drug Act related to home health services have not been completed. As you know, this data was due January 1, 1984. Could you tell me what has been done to date, and when I can expect a full report?

A The reports and recommendations in P.L. 97-414 to be submitted January 1, 1984, have been prepared and are presently under review in the Department prior to submission to the Congressional committees as specified in the statute.

QUESTIONS ON THE NATIONAL HEALTH SERVICE CORPS

1. Q We are aware of a number of inquiries from the National Health Service Corps scholarship students who feel that Corps assignment policies and priorities have changed over the last several years. Please describe any recent changes the Corps has made in its placement policies and how these effect the National Health Service Corps scholars. Also, please explain how the health manpower shortage area opportunity list is used to place these scholars?

A The mission of the NHSC, to provide health manpower to those communities of greatest need who are unable to recruit or retain such individuals, has remained constant. Over the several years that the NHSC has been in existence, major changes have occurred in the numbers of practicing health professionals, where those health professionals have chosen to establish their practices, and in the types of communities which continue to have difficulty recruiting or retaining adequate health manpower on their own. For example, in the past 7 years, the number of practicing physicians has increased by nearly 60,000, accompanied by a significant diffusion of these practitioners into communities which previously did not have access to health care.

NHSC policy still insures that our assignees are placed only in those communities of greatest need; however, the geographic location, specialty requirements, and type of assignments have changed in response to the societal changes described. NHSC scholars face fewer placement opportunities now than several years ago due to these social changes. NHSC scholars who are not residency trained face more competition for assignments than several years ago. And, more NHSC scholars are encouraged to consider the Private Practice Option (PPO) for placement than in past years. In a recent letter to all scholarship recipients, Kenneth P. Moritsugu, M.D., M.P.H., Director of the NHSC, discussed these social changes and their impact on the communities the NHSC serves, and thus, on the placement opportunities available for scholars in Health Manpower Shortage Areas (HMSA).

The other relatively recent change in placement policy has been the implementation of a HMSA Placement Opportunity List (HPOL) compiled with the cooperation of local, State, regional, and national agencies. When the restriction on utilizing the PPO in areas of greatest need was removed in the Omnibus Budget Reconciliation Act, this was interpreted by some scholarship obligors that they may serve under the PPO in any HMSA of their choice without regard to the relative needs of the area, the placement strategy of the program or the process for making placement. This was clearly not the intent of the legislation which eased the restrictions to bring placement of PPOs into balance with placement of Federal assignees. Except in unusual circumstances, as determined by the Administrator of the Health Resources and Services Administration (HRSA), all PPO placements can be approved only if they are on the HMSA opportunity list.

The purpose of the HPOL is to assure a more equitable distribution of health manpower by listing each States' available placement opportunities with respect to their need to eliminate HMSAs. All HPOL sites are in priority order to ensure an equitable geographic distribution while displaying each major specialty group of need.

This listing enables NHSC obligors to consider only those opportunities previously determined to be appropriate for their specialty. This list has proven to be the essential first step in targeting obligors to approved HMSAs and will continue to aid in refining a placement process that, in subsequent years, assures private practice and Federal placements in areas of greatest need.

NATIONAL HEALTH SERVICE CORPS

2. Q In 1981 the Secretary of Health and Human Services was asked to evaluate the then current health manpower area criteria to determine whether use of the criteria had resulted in areas that do not have an actual shortage of health manpower being designated as health manpower shortage areas. Can you briefly summarize the results of the study and state what you think the impact of the study's findings have been on designations and why?

A The Report to Congress on the Evaluation of Health Manpower Shortage Area Criteria, prepared by the Bureau of Health Professions' Office of Data Analysis and Management and provided to Congress in September, 1983, contains the results of the congressionally mandated study of the criteria and procedures used for designating Health Manpower Shortage Areas (HMSA). As part of this study, efforts were made to assess the extent to which application of the current criteria has resulted in designation errors. The potential county-level designations under the criteria based on national data for physicians by county as of December 31, 1980 (which became available much later than that date) were compared with the actual designations made before that date, which were based (like all HMSA designations) on data supplied by applicants, health systems agencies, State health agencies, and comments received on proposed designations. Of the potential conflicts identified, many had already been resolved in the designation process during the interim between December 31, 1980 and the study. Only 20 counties out of the 846 designated at the time of reference, or 2.4%, were estimated to be inappropriately designated.

With regard to subcounty areas, conclusions were more difficult to draw since no national data base exists for such areas other than that which results from the designation activity itself. Case studies were therefore performed in a small sample of areas - rural areas of West Virginia and urban areas of New York City and Los Angeles. These studies were not generally conclusive in terms of the appropriateness of existing subcounty HMSA designations, but indicated that care must be executed in the definition and review of rational service areas for subcounty designations, particularly those in urban areas, since these definitions are volatile in terms of designatability of the areas involved. The case studies also pointed up the general lack of small area data and the difficulties and expense of its collection.

The general impact of the study's findings has been twofold. First, it confirmed the need for regular review of existing HMSA designations to maintain currency and accuracy. A major review of all HMSA designations made prior to January 1981 has since been carried out (over the period August 1983 to April 1984) and a review of HMSA designations made in 1981 is now in progress.

Secondly, the study has stimulated a much more careful look at urban area designations. Proposed urban rational service area boundaries are now being examined very critically in terms of what separates the proposed service area from contiguous neighborhoods, e.g., poverty level, racial and ethnic composition, etc., and more detailed documentation of access barriers is being required.

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3. Q In 1981 the Secretary of Health and Human Services was also asked to consider different criteria (including indicators of unmet demand and the likelihood that such demand would not be met in two years) which may be used to designate health manpower shortage areas. Can you briefly summarize the results of this study and state whether indicators of unmet demand will be used in placing NHSC health care providers in health manpower shortage areas.

A As a part of the same evaluation study referenced in question 2, a major research effort was undertaken by the Bureau of Health Professions to examine alternative criteria for identifying health manpower shortage areas as well as to examine methods for assessing unmet demand. The HMSA criteria were compared with four available alternative measures of underservice - the Index of Medical Underservice (a four variable index including physician-to-population ratio, infant mortality rate, poverty rate, and percent aged, used with the community health center/primary care grant program), the Utilization Deficit Index (a research index developed by Joel Kleinman of NCHS), the Deaths Averted Index and the Use/Need Index (indices involving Medicare expenditures per enrollee relative to mortality rates developed by Jack Hadley of the Urban Institute). These alternative indices did not perform as well as the current HMSA criteria in identifying areas with the manpower availability problems that Federal shortage area programs are mandated to address through placement of health personnel.

The study also found that the definition and measurement of unmet demand is an extremely complex problem in view of the data limitations faced by the designation program. No technically acceptable methodology for measuring unmet demand and no approach for predicting whether such demand will be met within a specific time frame was identified. Nevertheless, county-level data on a number of indicators, including indicators of need, economic demand, and attractiveness, were assembled and used to provide relative ranking of designated HMSAs in the 1984 NHSC placement cycle. Efforts were also initiated to develop better degree-of-shortage groupings for use in future priority rankings of designated HMSAs.

Meanwhile, the "dedesignation threshold," i.e. the number of additional practitioners required in a given area in order to remove it from the HMSA list under the shortage criteria, is being used by the Bureau of Health Care Delivery and Assistance (BHCDA) as a combined need/demand indicator in determininations about how many NHSC practitioners (whether private practice option, grant-funded, or federally-salaried) should be placed in a particular area.

This and other factors indicative of demand are used to select those HMSAs which are included on the "Placement Opportunity List" from which NHSC scholars may select and/or be matched to in the NHSC placement process. Areas on this list to which individuals are matched during the placement cycle have their designations and need/demand reconfirmed, including the use of information furnished by local medical and dental societies, immediately prior to actual service contracts being signed.

4. Q Section 338F of the Public Health Service Act authorized 550 new National Health Service Corps scholarships and continuation scholarships in each of Fiscal Years 1982, 1983, and 1984. Please explain how many of these scholarships were awarded in each of these Fiscal Years and to whom they were awarded (e.g., Exceptional Financial Need, Indian Health Service, Continuation awards)?

A The National Health Service Corps (NHSC) Scholarship Program made multi-year awards to former recipients of the Scholarship Program for First-Year Students of Exceptional Financial Need (EFN) and continuation awards to former recipients of the NHSC Scholarship Program as follows:

	FY 1982	FY 1983	FY 1984
Former EFN Awards	160	144	120
Continuation Awards	2,289	804	50

NATIONAL HEALTH SERVICE CORPS

5. Q— In Fiscal Years 1982, 1983, and 1984--how many National Health Service Corps scholarships recipients were sent to the Indian Health Service to fulfill their National Health Service Corps obligation? What do you project these numbers will be in Fiscal Years 1985, 1986, and 1987?

A The number of NHSC Scholarship recipients allocated to the IHS in the past three years were as follows: 1982 = 110, 1983 = 134, 1984 = 230. Our projected figures for allocations to the IHS for 1985 are approximately 177 individuals. There are no current estimates available for allocations to the IHS for 1986 or 1987; however, our expectation is that in 1986 a similar number will be needed.

NATIONAL HEALTH SERVICE CORPS

6. Q Please explain how the National Health Service Corps-State demonstration projects are working, that is, how many States have taken over NHSC responsibilities and what are their responsibilities?

A Currently, 27 States are involved in the NHSC-State demonstration project. Through contracts, these States are now actively involved in identifying areas in need of additional health manpower, validating the designation of existing HMSAs, developing new HMSA designations, working with communities in shortage areas to develop potential NHSC practice sites, and matching, placing, and managing NHSC practitioners. Fifteen of these demonstrations were begun approximately 2 years ago, 10 are completing a first year of operation, and 2 new contracts were recently negotiated. We are pleased with this demonstration experience and plan to develop demonstration projects with 4 additional States during the next fiscal year.

NATIONAL HEALTH SERVICE CORPS

7. Q Will the National Health Service Corps need all of the $91.0 million appropriated for Fiscal Year 1984? If not, please explain what amount is projected to be needed and why the difference?

A The short answer is that the NHSC will not need all of the $91.0 million appropriated for Fiscal Year 1984. The current projection is that the NHSC will need approximately $23 million less for its operations in Fiscal Year 1984. This revised estimate was incorporated in P.L. 98-396.

The reason for the difference relates to the change in placement of NHSC scholars from primarily federally salaried individuals to Private Practice Option (PPO) and Private Practice Assignment (PPA) positions. In August 1981, the authorizing legislation of the NHSC was revised to expand greatly the ability of the NHSC Scholarship obligors to fulfill their obligations through private practice (the PPO) and through non-Federal employment (the PPA) alternatives. Experience has proven the new options a success and as a result the NHSC needs less than it originally projected. In addition, current projections indicate that only about $350,000 of the $500,000 appropriated for the NHSC Start-up Loans will be required.

8. Q What efforts are being conducted by the Department to check the validity of Health Manpower Shortage area supporting data? Overall, are the number of shortage areas increasing or decreasing? Please explain.

A The HMSA designation process, under published regulations carried out by the Bureau of Health Professions' Office of Data Analysis and Management, has two built-in validity checks. First, all designation requests are automatically sent to the appropriate State Health Planning and Development Agency, Health Systems Agency, and State Medical or Dental Society for review and comment before action is taken. This provides these entities with the opportunity to verify the supporting data. Staff also routinely contacts these offices by telephone when questions arise. Secondly, following any actual designation, these and other interested parties are notified by furnishing them a copy of the letter making the designation; this letter includes the basic data which were accepted at the time of designation. Thus, interested parties have an opportunity to challenge the designation based on the data used if they find it to be incorrect. In addition, the staff which makes the designations has available the latest national data by county, the names, specialites and addresses of most physicians by city and town within county (through copies of published directories), and 1980 census population data by census tract and/or civil division. These references are routinely checked for basic consistency with data provided in requests, in order that major discrepancies can be followed up with the applicant.

More specifically, as mentioned in the answer to Question 2 (NHSC), a comprehensive review of all HMSAs was undertaken in August 1983 with emphasis on those areas designated prior to January 1981. The result of this review, which involved the agencies mentioned above and was completed in April 1984, was an overall reduction in the number of primary care HMSAs by 22 percent. (Of the 2176 designations in force at the beginning of the review, 1539 were continued in force while 637 were withdrawn. Meanwhile, 166 new designations were made, for a net reduction of 471.) This decrease seems largely to represent the factors of national increases in the numbers of available physicians and the diffusion of more of these physicians into rural areas. This trend seems likely to continue, according to a recent study by the Bureau of Health Professions' Office of Data Analysis and Management. However, significant numbers of areas and population groups with intractable shortages also appear likely to remain.

NATIONAL HEALTH SERVICE CORPS

9. Q Please describe any recent changes in National Health Service Corps urban versus rural placement policy? Specifically, what criteria are used to place an area on the health manpower shortage area opportunity list?

A The NHSC has no policy which specifically favors urban or rural placements. In fact, the actual distribution of scholars between urban and rural sites approaches an even distribution, reflecting a tangible program recognition of the need for assignments in both urban and rural areas. Over the past few years, the distribution has essentially remained constant at 53 percent rural and 47 percent urban, and the same distribution is expected for 1985.

There are a number of factors which affect the diffusion of physicians into an area, and these factors may affect the future distribution of rural versus urban HMSAs which, in turn, may impact upon future availability of NHSC placement opportunities. These factors include the accessibility of professional support, social amenities, the economic environment, and the availability of hospital beds.

For both rural and urban sites, the same criteria is used when assessing a site for placement on the HPOL. The first qualifying criteria is that the site must be in or serving a HMSA. For the most part, these are geographic designations. In special cases, however, a population or institutional designation can be applied. The site must also have the means to support the desired health professional and the practice. In the case of a PPO assignment, the economic situation must be conducive to the successful establishment of a private practice. In the case of a Federal or PPO assignment, the site must provide the facility, equipment, and ancillary staff to support the professional's practice.

An important final criteria involves the relative need of the community for health manpower compared to other such sites in the State, region, and nationwide. This determination is made carefully with the input of local, State, regional, and national organizations. Only those sites of truly greatest need can qualify for inclusion in the HPOL.

QUESTIONS ON CHILDHOOD IMMUNIZATION

1. Q What is the background to the Department's proposal for a campaign to eliminate rubella (German Measles)? Specifically, has the number of new cases of rubella increased recently? What is the Department currently doing to eliminate or reduce the number of cases of rubella?

A Although major epidemics of rubella have been prevented and reported cases of rubella reached record lows in 1983, endemic transmission still occurs resulting in an estimated 110 cases of congenital rubella syndrome (CRS) each year, at an estimated lifetime cost in excess of $24 million. The four major birth defects related to CRS are deafness, impaired vision, mental retardation, and congenital heart disease. However, any organ system is at risk for involvement. Current efforts against rubella are limited to the comprehensive immunization of preschool and school age children against the childhood vaccine--preventable diseases and outbreak control activities. Maintenance of this level of effort will lead to the disappearance of CRS over the next 15-20 years. The rubella initiative offers the opportunity to hasten the elimination of this personal and societal tragedy within the next 7 to 10 years. The most important addition to current activities will be the improvement of immunization levels in women of childbearing age.

The rubella and congenital rubella syndrome elimination strategy will have the same basic components as measles elimination. They are:

a. Achieving and maintaining high immunization levels with special emphasis placed on women of childbearing age (ages 15-44).

b. Intensive disease and vaccine usage surveillance.

c. Aggresive outbreak control.

It is estimated that over 6 million of the 41 million young women who have left high school and are now in the childbearing ages are susceptible to rubella and will be the most difficult to reach. Assuring high immunity levels in this group will require efforts directed in the following settings:

a. College immunization requirements.

b. Immunization in family planning clinics.

c. Post-partum and post-abortion immunization.

d. Immunization by family practice and gynecological physicians.

e. Immunization of health care workers.

The majority of these efforts will be carried out through State and local health agencies supported with project grants, although we anticipate that many of those needing immunizations will obtain them through existing public or private sources or through employment programs. Activities at the national level will include program direction, evaluation, disease surveillance, outbreak control, and public education and training.

CHILDHOOD IMMUNIZATION

2. Q The Department is requesting $4.0 million in Fiscal Year 1985 in order to increase the vaccine stockpile to 16 weeks. The Department's goal is to achieve a stockpile of 26 weeks (6 months). What is the justification behind the 26 week stockpile and how much would this increase cost the Government?

A A 6-month stockpile of vaccine is necessary because FDA estimates if production of a vaccine were to be totally interrupted, it would take 6 months or more to re-establish production or to license a foreign manufacturer who is already in the business of producing vaccine. The FDA estimate is based on the following timetable:

Minimum time needed to grow cultures and manufacture vaccine.	1 month
Average time needed for manufacturer to conduct animal tests required by FDA to ensure vaccine potency and efficacy. For complex vaccines (e.g., polio) or major production problems, FDA requires manufacturer to produce and test five consecutive lots of quality vaccine.	4 months
Approximate time needed for product labeling and distribution.	1 month

The amount of additional money needed to achieve a 26-week stockpile in Fiscal Year 1985 depends upon when the money becomes available. If additional funds are made available early enough for vaccine to be purchased prior to expiration of the present contract on December 31, 1984, an additional $11,039,600 will be required to complete the purchase of oral polio; measles; mumps; rubella; tetanus and diphtheria toxoids - adult; and inactivated polio--the currently stockpiled vaccines. If funds are not available in time to purchase vaccine before December 31, 1984, the cost to complete the stockpile would increase to $12,108,920, an additional $1.1 million or 10 percent above current prices.

QUESTIONS ON VENEREAL DISEASE

1. Q Your testimony indicates that an increasing number of sexually transmitted diseases other than gonorrhea & syphilis are affecting our population. Herpes and non-gonococcal urethritis are serious problems that are becoming more prevalent in this country. What are State grant programs doing for patients with herpes and non-gonococcal urethritis?

A CDC provides active leadership and support for national efforts directed toward the prevention and control of sexually transmitted diseases (STD) through project grants to States and program operations carried out at the national level. Venereal disease control grants are awarded to all States, territories, the District of Columbia and some local health jurisdictions. Sixty-four grants are presently in operation.

Control efforts in areas such as herpes and non-gonococcal urethritis/chlamydia require further technological advancements. Herpes has no effective cure, and control programs for chlamydial infections lack simple and inexpensive diagnostic techniques.

In FY 1984, four States received grants under section 318(b) authority to establish and evaluate pilot chlamydial control efforts. In addition, CDC currently has a cooperative agreement, funded through grant funds, with the Institute for Health Policy Studies, University of California (San Francisco) to study, develop, and evaluate cost-effective analytical models for defining/specifying chlamydial control strategies.

In chlamydial intervention efforts, 25 grantees recently reported that STD clinics within their jurisdictions provide therapy for specific related infections. Nine areas appear to have fairly comprehensive program activities, including the culturing of patients, the treatment of infections, and the counseling and referral of sex partners. A total of 44 areas have public health or other laboratories involved in expensive cell culture procedures for the identification of the organism. The majority of grantees also have some counseling services available to herpes patients. This counseling involves the steps that need to be taken by patients to reduce the pain of their recurring symptoms as well as the necessary steps to reduce the risk of exposing other sex partners to this infection.

The STD National Hotline, funded through special 318(b) grant funds, provides information as well as referral services to over 65,000 callers a year. Approximately 90 percent of the calls are related to STD other than gonorrhea and syphilis. Approximately 50 percent of the calls relate to herpetic infections. This information and referral service permits callers to quickly obtain information on potential signs and symptoms as well as the address of their closest STD clinic. Through this referral system, control programs more quickly address the diagnostic and treatment needs of STD patients, thus reducing the potential for disease transmission in the community.

Ten STD Prevention/Training Centers were in operation in FY 1984 and, by the end of the Fiscal Year, will have provided clinical training in herpes, chlamydia and other sexually transmitted diseases to over 2000 health care providers from the public as well as private sector. State grantees have participated in this training system by supporting the training of key staff members of their STD clinic.

While the STD Prevention/Training Centers are an important first step in training STD health care practitioners, there is a basic need to reach clinicians during their initial formal training. Through the use of special 318(b) grants in FY 1984, 6 demonstration projects from medical schools were funded for the development and implementation of STD curricula into their medical instruction program. This activity requires a significant STD didactic component within the medical school and liaison relationship between the faculty members and the local STD program and its clinic for the clinical training component of the curriculum. The curriculum will concentrate on the expanded spectrum of sexually transmitted diseases/syndromes, including herpes and chlamydial infections.

2. Q Some of the victims of sexually transmitted diseases are babies who acquire these diseases at birth. Do we know how many babies in this country are being affected by V.D.? Do you feel we are adequately addressing this problem?

A The exact number of babies affected by STD is not known. However, the following estimates have been made:

- Five percent of the babies born each year in the United States will have chlamydial infections. Of these:
  - -- 50 percent will develop eye infections
  - -- 20 percent will develop pneumonia
  - -- An unknown percentage will develop ear infections which may result in deafness
- Approximately 150 cases of congenital syphilis in children under 1 year of age are reported each year. For pregnant women with untreated syphilis, the risk of miscarriage or stillbirth is 40 percent; for delivery of a congenital infant, 40 percent; and for delivery of a normal infant, only 20 percent.
- Approximately three out of every 10,000 newborns are infected with genital herpes. It is estimated that fifty percent of the infected newborns, if untreated, will die and half of the infected newborns will suffer serious mental retardation.
- Congenital infections caused by cytomegalovirus (CMV), a portion of which may be sexually transmitted, is estimated to occur in 1.5 percent of all pregnancies, affecting 55,000 infants annually. Fifteen percent of the infants will be retarded, deaf, or suffer from visual defects.
- Group B Streptococcus, a portion of which may be sexually transmitted, is estimated to cause symptomatic disease in 12,000 infants under 3 months of age each year. The disease is also responsible for 5,000 annual infant deaths.

Within current budget priorities intensive efforts have been directed toward community projects designed to improve prenatal services and reduce the potential for congenital syphilis.

CDC's efforts to address neonatal STD in Fiscal Year 1984 include: Implementing a pilot national neonatal herpes surveillance project to better define the problem of neonatal herpes infections and to develop the information necessary to design prevention measures; funding two special 318(b) demonstration projects designed to improve prenatal care and reduce the potential for neonatal STD; and operating ten STD Prevention/Training Centers to provide over 2000 participants with skill improvements in diagnostic approaches to all STD, including the proper management of pregnant females and pediatric cases.

QUESTIONS ON TUBERCULOSIS

1. Q Dr. Brandt, could you comment on the extent of Tuberculosis in this country and the degree to which this problem is remediable?

A Tuberculosis is now a curable and preventable disease. Nevertheless, tuberculosis has not been eliminated from the United States, and it is not likely to disappear in this century.

Approximately 10 million persons, or about 5 percent of the Nation's population, are infected with tuberculosis. In 1983, 23,846 cases of tuberculosis were reported to the CDC, for a rate of 10.2 cases per 100,000 population. Compared with 1982, this represents a 6.6 percent decrease in the number of cases reported and a decline of 7.3 percent in the rate.

In 1983, 1,360 tuberculosis cases were reported among children under 15 years of age, including 818 cases among children less than 5 years of age; in 1982, there were 1,349 cases and 769 such cases, respectively.

Final tuberculosis mortality data for 1981 show 1,937 deaths, compared with the final totals of 2,007 and 1,978 deaths in 1979 and 1980. There has been essentially no change in tuberculosis mortality over the 4-year period 1979-1982.

Three things can be done to help remedy the tuberculosis problem in the United States. They are: More intensive application of technologies already in use, such as supervised therapy, 9 months of short-course chemotherapy, and preventive treatment; widespread transfer to the field of recently developed technologies, such as rapid laboratory identification of Mycobacterium tuberculosis, phage typing, and 6-month short-course treatment regimens; and development of new technologies, such as a screening test to identify high-risk infected persons, short-course preventive therapy, and an effective immunizing agent.

ADMS BLOCK GRANT QUESTIONS

1. Q What programs are currently being administered that recognized the special needs of women and substance abuse? Do you feel that the Federal Government is adequately addressing the special needs of women who abuse alcohol and drugs?

A Under the ADMS block grant, each State undertakes a needs assessment to determine the particular needs of its population. This needs assessment determines special needs, such as those of women and substance abuse, within that particular State. The State then develops an intended use of funds plan which is reviewed by the citizens of the State, including any organizations representing groups having special needs. Comments received are incorporated into the State's intended use plan and brought before the State Legislature for review and once again an opportunity is offered for citizen input around special needs, e.g., of women who abuse alcohol and drugs, or other categories of service recipients. The Federal Government's role is to ensure that groups are provided the opportunity to impact upon the determination of the funds utilized and thus channel funds according to the State's particular needs.

2. Q Since the block grant was enacted in 1981, what types of data collection efforts have been undertaken? Do you think it is necessary to develop some type of national data collection effort? If so, how would you propose to tailor this type of effort?

A (a) Data collection activities relevant to tracking and establishing incidence and prevalence data have been continued, e.g., sample surveys and inventories relevant to reporting of mental illness as well as the national senior high school survey, the Drug Abuse Warning Network, the National Drug and Alcoholism Treatment Utilization Survey, and the National Household Survey (latter four activities are related to substance abuse). A number of collaborative data collection activities have been continued with other Federal agencies, e.g., National Center for Health Statistics, Health Resources and Services Administration, Health Care Financing Administration, Department of Transportation, Veterans Administration, and Bureau of Prisons.

(b) The uniform national data strategies jointly implemented by the States, Federal Government, and national ADM associations are the basis for a national data collection effort. A majority of the States support the continuation of these activities. States serving in an advisory capacity or in _ad hoc_ forums with national association and federal officials feel confident that progress is being made and that their data needs are being addressed and met.

(c) The success of a national data collection effort is contingent upon the continued Federal, State and national association participatory approaches. These national uniform data collection approaches are not tailored to the ADMS block grant. Rather, national data serves many purposes and needs. Efforts in tailoring data strictly to ADMS block grant needs may have negative results.

ADMS BLOCK GRANT

3. Q Can you please identify whether or not the ADAMHA block grant funds are going for services for the chronically mentally ill? Is there a need to address underserved populations or to meet the unique needs of other groups?

A Review of the ADMS block grant applications for the 3 Fiscal Years of the block grant's existence indicates that States have determined the chronically mentally ill to be one of the major groups requiring funds. A review of the annual reports for FY 82 and FY 83 indicates that the chronically mentally ill have been receiving services funded by the ADMS block grant. An analysis of the findings of the 24 State compliance reviews completed indicates that the requirement in section 1915(c)(3) providing special emphasis on funding of the chronically mentally ill is being responded to by the States and that the services are being made available.

Under the current legislation, each State undertakes a needs assessment which identifies underserved populations or groups within the State which have unique needs. The needs assessment is then translated into a State intended use plan which is reviewed by the citizens and offers opportunity for underserved populations or unique groups to impact upon the funding decisions. The revised plan incorporating the comments of the citizens is then brought before the State Legislature where, once again, the opportunity for public comment concerning specialized groups is provided.

4. Q In administering the block grant funds to the States, can you describe the relationship between the Department of Health and Human Services and the States? Can you give your impressions about the changes and what you have learned through the ten audits you have conducted.

A During the 3 years that the Alcohol and Drug Abuse and Mental Health Services (ADMS) block grant has been in existence, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) has developed a close, cooperative working relationship with the States in the administration of the program. This cooperation is reflected in the development of nonburdensome, nonprescriptive guidance being provided to the States concerning their application and reporting requirements around the ADMS block grant and the provision of technical assistance as requested by the States, as well as around necessary "investigations," such as the State compliance reviews. ADAMHA has been working very closely with the States and the national organizations (National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors, National Association of City Alcohol and Drug Abuse Coordinators, National Governors Association, etc.) in developing a cooperative relationship whereby problems of each of the components can be discussed in an open forum and a mutually beneficial approach developed. Based on the 24 State compliance reviews which have been performed so far, the comments received from the States vis-a-vis their relationship with ADAMHA have been almost without exception complimentary toward ADAMHA staff regarding the compliance reviews and the assistance provided during those reviews. It has been a goal of ADAMHA to assure a close relationship with the States while not imparting burdensome requirements, such as format or guidelines, that the States must follow in the accomplishment of ADMS block grant supported projects. Indications of the success of this approach have been received during participation in national association meetings and other forums.

5. Q The block grant currently requires that 20 percent of monies be used for alcohol and drug abuse prevention programs. As an advocate of prevention, I am always interested in learning what the States are doing to prevent alcohol and drug abuse. Can you describe some of the initiatives States have undertaken?

A Section 1915(c)(8) of the Alcohol and Drug Abuse and Mental health Services block grant legislation (Omnibus Budget Reconciliation Act of 1981) requires the recipient to use not less than 20 percent of the funds allocated for alcohol or drug abuse activities for prevention and early intervention programs which are designed to discourage the abuse of alcohol or drugs or both. Review of the applications and annual reports as well as the 24 State compliance reviews thus far completed indicates that the States are utilizing the 20 percent "earmark" for prevention activities in a variety of ways. The prevention activities reviewed or observed include the development of statewide education programs directed at the school system which will provide students with accurate material concerning alcohol and/or drug abuse information, education of law enforcement agencies and/or legal systems in identifying potential alcoholic and other driving while intoxicated (DWI) related information, educational programs for children concerning potential drug abuse, parental abuse, etc.

6. Q Some national studies, including NIDA's efforts, indicate a down turn in certain types of drug abuse among high school seniors. Can you elaborate on the experiences of States with regard to drug and alcohol abuse among youth? And do you include all teenagers in your survey including the dropout population?

A The National Institute on Drug Abuse (NIDA) conducts two national surveys that have, in recent years, documented a downturn in drug use by American youth. Both surveys are designed to yield national level estimates based on scientifically drawn samples. These estimates are used to plot trends over time which tell us if the prevalence of drug abuse and misuse is increasing, decreasing, or remaining stable. Results of the surveys cannot be generalized to populations other than their respective national target populations. That is, results from the High School Senior Survey cannot be used to reflect drug use in State or local communities, or of school dropouts or younger children. Similarly, results from the Household Survey do not reflect drug use by persons not living in households, although school dropouts and young teenagers are included. The Institute has studied the effect of school dropouts on the estimates produced by the High School Senior Survey. This review concluded that, even though drug use may be considerably higher among absentees and dropouts, a high level of use within a comparatively small proportion of the general population has little impact on the overall estimates. Also, trends from year-to-year are not affected since the adjustments for unsampled groups are likely to remain constant from one year to the next.

ADMS BLOCK GRANT

7. Q Do you have any plans for proposing changes in the allocation formula for the ADAMHA block grant?

A The Administration has not proposed any changes in the ADMS block grant allocation formula. ADAMHA has expressed its willingness to work with the Congress to undertake any studies concerning a more equitable allocation formula for the ADMS block grant, should the Congress determine that such studies should be be undertaken.

ADMS BLOCK GRANT

8. Q Are you aware of any issues in service delivery that may need further research?

A The Alcohol and Drug Abuse and Mental Health Services block grant is a mechanism for funding service delivery to defined populations in a State. It is not to be utilized in the sponsoring of research activities pertaining to alcohol, drug abuse, or mental health services, except that some evaluation activities may be supported by the alcohol and drug abuse portion of the block grant. There are many ADMS service delivery research projects currently supported by the Alcohol, Drug Abuse, and Mental Health Administration, but these are not being supported under the ADMS block grant.

9. Q As a follow-up to the recommendation in the Office of Technology Assessment Report on "The Effectiveness and Costs of Alcoholism Treatment", what studies have you undertaken and/or what data have you collected on the cost of alcohol and drug problems, on the relationship of alcohol and drug problems and services to health care costs and on the effectiveness of treatment programs?

A The Research Triangle Institute, under contract to the Alcohol, Drug Abuse, and Mental Health Administration, conducted a study entitled "Economic Costs to Society of Alcohol, Drug Abuse and Mental Illness" which was based on statistics through 1977 and reported on in 1981. This study is currently being updated by the Research Triangle Institute under an ADAMHA contract. A project jointly funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Health Care Financing Administration (HCFA) entitled "The HCFA Alcoholism Services Demonstration Evaluation" addresses the relationship between alcoholism treatment services and health care costs and alcoholism treatment program effectiveness. The investigation of the former issue is based on a sample of approximately one hundred (100) treatment programs located in six States, i.e., New Jersey, Connecticut, Michigan, Illinois and Oklahoma. Plans call for the investigation of the latter issue in a subsample of the programs in New York, New Jersey, and Michigan. This project is scheduled for completion in December 1986.

Although many of our activities were initiated prior to the Office of Technology Assessment Report and cannot necessarily be considered as followup to the recommendations, they do address the issues. For example, an analysis of 12 selected studies on the cost of alcoholism services in employee-based alcoholism programs and organized care settings determined that alcohol treatment was followed by reduction in medical care utilization and costs ranging from 26% to 60%.

In another study of State employees in California, 90 families with an alcoholic member, all enrolled in Blue Cross/Blue Shield, were followed for a period of 5 years. The study indicates that the total medical care costs per family member decreased substantially over time once the alcoholic family member entered treatment. At the conclusion of the study, inpatient costs per person per month of both control families and the alcoholic families were similar and the outpatient costs of the control families were actually higher.

Another such effort examined economic impact in relation to insurance finance mechanisms, utilizing findings from a number of studies of alcoholism treatment. This study estimates that the average annual reduction in total health costs range from about $790 per person for fee-for-service plans to some $1,650 per person for pre-paid plans.

While NIAAA has sponsored a variety of health care costs studies in the past, there is a need to increase the information and experience available in the alcoholism field. Therefore, NIAAA is continuing these efforts and has arranged with the Office of Personnel Management and Aetna Life and Casualty to conduct an indepth analysis of cost and utilization data with regard to Aetna's Federal Employee Health Plan alcoholism and drug abuse benefit. This study has been designed to obtain health care cost offset information.

NIAAA believes these and other studies indicate that treatment for alcohol abuse and alcoholism is frequently followed by a reduction in medical care utilization as well as reduced costs.

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